SAMHSA FY16-17
Alabama Mental Health Block Grant Application

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Section II: Planning Steps – Step 1: Assess the strengths and needs of the service system to address specific populations

Overview and Organization of the Public Mental Health Service Delivery System

The Alabama Department of Mental Health (ADMH) was created under Act 881 of the 1965 legislature and was charged with the responsibility of establishing a public mental health system. The Department is responsible for mental illness, intellectual disability, and substance abuse services. The Department serves as both the Single State Authority (SSA) for the Substance Abuse Prevention and Treatment Block Grant, as well as the State Mental Health Authority (SMHA) for the Community Mental Health Services Block Grant (SAPT/CMHS). The Department is responsible for operating state psychiatric facilities, establishing standards for community services, and is empowered to contract for services. The Commissioner of ADMH, and other Departmental staff coordinate services with other state agencies such as the Department of Human Resources (child welfare – adult and child protective agency), Department of Youth Services (juvenile justice), Department of Corrections, Department of Public Health, and Medicaid. ADMH is involved in coordinating services with these agencies through multiple committees, workgroups, and daily contacts. Services are coordinated both for individuals and for systems of care.

The Commissioner of the ADMH is a cabinet member appointed by the Governor. Gubernatorial elections were held for the 2011-2014 term. Upon taking office in January 2011, newly elected Governor Robert Bentley appointed Zelia Baugh as the Commissioner for the Department of Mental Health which dismissed the standing Commissioner, John Houston. Commissioner Baugh changed many of her executive staff positions, to include the Associate Commissioner of Mental Illness (Acting Dr. Beverly Bell-Shambley), Associate Commissioner of Substance Abuse (Dr. Tammy Peacock), and Associate Commissioner of Developmental Disabilities (Ann White-Spunner).

Commissioner Baugh set forth a new vision which included merging the long separated Mental Illness Division and Substance Abuse Division. Historically the ADMH Division of Mental Illness, under the direction of the Associate Commissioner, has responsibility for operation of state psychiatric hospitals and the development and coordination of the system of community treatment services for mental illness. This responsibility includes contracting for services with local providers and monitoring those service contracts, evaluation, and certification of service programs in accordance with statutory standards, implementation of a joint hospital and community Performance Improvement Plan, and planning for the development of needed services. In addition to the Offices of Community Programs, Certification, and Performance Improvement, the Division of Mental Illness includes an Office of Consumer Relations and an Office of Deaf Services.

With the merging of the Division of Mental Illness and the Division of Substance Abuse Services, ADMH went from having three service divisions (MI/SA/DD) to two services divisions – the Mental Health Substance Abuse Services Division and the Developmental Disabilities Services Division. The newly appointed Associate Commissioner, Dr. Tammy Peacock, became the Associate Commissioner of the Mental Health Substance Abuse Services Division. Much work occurred to break down “service silos” that have long existed between the traditionally separate Mental Illness and Substance Abuse Divisions while at the same time providing better recovery-oriented services for those individuals with mental illnesses, substance use disorders, and co-occurring disorders.

On June 2012, Commissioner Zelia Baugh tendered her resignation with this being effective June 30, 2012, as well as the departure of two of the Associate Commissioners, Ann White-Spunner – Developmental Disabilities Service Division and Dr. Tammy Peacock – Mental Health and Substance Abuse Services Division. Governor Bentley appointed as the new Commissioner of Mental Health Jim Reddoch, effective July 2012. Commissioner Reddoch appointed three new positions – Associate Commissioner of the Developmental Disabilities Division, Courtney Tarver; Associate Commissioner of Mental Health Substance Abuse Services Division, Dr. Beverly Bell-Shambley; and General Council of ADMH, Tommy Klinner.

On July 1, 2015, Commissioner Jim Reddoch retired and the Governor appointed James V. Perdue as the Commissioner of the Alabama Department of Mental Health. Prior to his appointment as commissioner, he served as the Probate Judge for Crenshaw County for 12 years. He also served as President of South Central Alabama Mental Health Board and as a member of the Alabama Mental Health Advisory Board of Trustees. Commissioner Perdue maintained the executive staff of Associate Commissioner of the Developmental Disabilities Division, Courtney Tarver; Associate Commissioner of Mental Health Substance Abuse Services Division, Dr. Beverly Bell-Shambley; and General Council of ADMH, Tommy Klinner.

In FY10, there were six state-run mental illness inpatient treatment facilities serving adults in Alabama. Bryce Hospital in Tuscaloosa operated an acute unit and an extended care unit. In October 1, 2010, the Department of Mental Health contracted with the University of Alabama Department of Psychiatry and Behavioral Neurobiology to operate the Adolescent Unit that was formerly operated by Bryce Hospital. Two other facilities operate in Tuscaloosa: Taylor Hardin Secure Medical Facility providing services for Alabama's male forensic psychiatric population and the Mary Starke Harper Geriatric Psychiatric Center, providing specialty geriatric services. Searcy Hospital in Mt. Vernon (near Mobile) operated an acute care unit and an extended care unit. North Alabama Regional Hospital in Decatur, AL operated acute care units. Greil Hospital in Montgomery, AL operated acute care units.

Due to severe budget reductions and a decrease in state dollars for ADMH by approximately $40 million over a four year period of time, FY12 provided unique planning opportunities for ADMH and its long-standing partners (consumer and family advocate groups, providers, judges, hospitals, etc.). Through two ADMH Administrations, much direct focus and planning was given to determining to most effective way to move toward a transformed system that could be provided with such funding cuts. This planning process led to a restructuring in how ADMH would provide post commitment care to consumers civilly committed (Probate Court commitments) to ADMH and the process would have to occur over a multiple year process to achieve true statewide restructuring. However to address the budget demands in FY12, most all of the efforts of ADMH was focused on the closure of two state-run mental illness inpatient treatment facilities serving adults in Alabama. To accomplish this meant building an infrastructure within communities of Region 3 and Region 4 (both in the southern portion of Alabama) which included an array of services to include Designated Mental Health Facilities (ADMHF) to provide post-commitment care that would replace this service being provided in a state-run psychiatric hospital. By implementing this process, ADMH was able to close Searcy Hospital in Mt. Vernon (near Mobile) operating an acute care unit and an extended care unit and Greil Hospital (in Montgomery) operating acute care units.

In FY13, ADMH expanded the restructuring of the process for serving civilly committed patients and focused our efforts on the other regions which primarily utilized Bryce State Hospital and North Alabama

Regional Hospital. ADMH experienced some shifting the budget that allowed for some expansion dollars to be utilized to implement a similar process in the mid to northern part of the state as we had done with the southern end of the state. This effort was primarily of importance as Bryce Hospital was preparing to enter into a new, state of the art, facility with a much smaller bed capacity. The new Bryce became operational in July 2014. By October 1, 2014, the two regions involved with this process had achieved their restructuring goals by utilizing ADMHFs in their areas to serve committed patients. In January 2015, ADMH announced the intent to close North Alabama Regional State Hospital and all efforts were made to achieve this goal in coordination with community providers, family members, advocates, and the consumers receiving treatment at this state hospital. North Alabama Regional State Hospital had the last patient served there June 17, 2015.

As of July 2015, there are three state-run mental illness inpatient treatment facilities serving adults in Alabama:

- Bryce Hospital in Tuscaloosa operates an acute unit and an extended care unit.
- Taylor Hardin Secure Medical Facility in Tuscaloosa operates units for Alabama's male forensic psychiatric population
- Mary Starke Harper Geriatric Psychiatric Center in Tuscaloosa operates units providing specialty geriatric services.

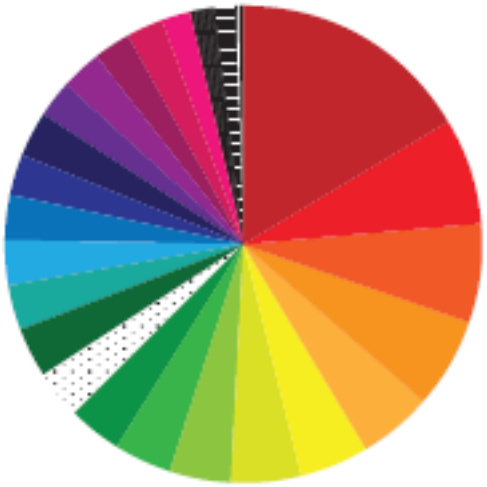
Through the Juvenile Code in Alabama, the courts have the authority to commit adolescents to ADMH for psychiatric stabilization in cases where the criteria outlined in the juvenile law is met. As these are adolescents, through the Juvenile Commitment, the minor is placed in the custody of ADMH for the purposes of providing psychiatric treatment. Once the committed youth consumer has met maximum benefit from commitment to ADMH, the court releases ADMH from commitment and re-establishes custody with an entity other than ADMH. Prior to October 2010, the care for committed youth was provided in a state-run mental illness inpatient treatment facility serving adolescents at Bryce Hospital in Tuscaloosa. With appropriate amendments to the Juvenile Code, the Commissioner of ADMH was provided the authority to have such committed youth consumers served in a state-run mental illness inpatient treatment facility or with a contracted inpatient treatment facility. In October 1, 2010, the Department of Mental Health contracted with the University of Alabama Department of Psychiatry and Behavioral Neurobiology to operate the ADMH Adolescent Psychiatric Unit at UAB.

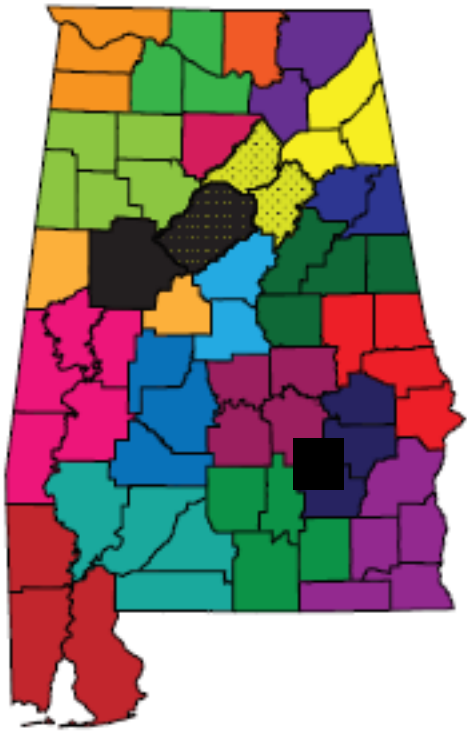
The public community mental health services system was based upon 22 service areas. In April 2014, two of the community mental health providers merged, producing 21 service areas. There are now 21 public, non-profit regional mental health boards (called 310 Boards based on ACT 310 of the 1967 Regular Session of the Alabama Legislature). There are 24 community mental health centers in the 21 service areas. The Birmingham area has a regional 310 Board and three mental health centers. Outside of the Birmingham area, the mental health centers are organized with a main center in the most populous county or city in their catchment area and satellite offices in outlying counties/areas. Each one of the 67 counties, with the exception of one, has a full-time office. The mental health centers provide a continuum of services to all ages with a focus on adults who have a serious mental illness and youth who have a severe emotional disturbance. In some areas, the mental health center also provides services for those who have intellectual disabilities and/or substance use disorders. In addition to the community mental health

centers, the Department contracts with two specialty child and adolescent service providers: 1) Brewer-Porch in Tuscaloosa and 2) Glenwood, Inc. in Birmingham.

Community services are funded through a mix of resources including federal MH Block Grant funds, state funds, Medicaid, Medicare, other third party (insurance), local government, donations, and client fees generated under a sliding fee scale. The level of city and county support for these providers varies significantly across the state. In addition to contracting with ADMH, providers may also enter local arrangements with the Department of Human Resources, the Department of Youth Services, and local education agencies. In FY 2016, block grant funds will account for approximately 2.7% of ADMH contracts for Community Mental Health services while state sources such as the General Fund, Special Mental Health Fund and other state sources accounted for 62.5% of total resources. Medicaid reimbursements and other federal funding account for an additional 34.8% of the ADMH Community Mental Health budget. This does not include support that is provided by local sources, the proportion of which varies greatly from center to center.

Community Mental Health Service Areas





Community Providers Breakdown

- AltaPointe Health Systems
- East Alabama MH Board
- Wellstone Behavioral Health
- Riverbend Center for MH
- Indian Rivers
- CED MH Board
- JBS MH Authority
- Northwest AL MHC
- MHC of North Central AL
- South Central AL MH Board
- Eastside MHC*
- Cheaha Regional MH/MR Board
- Southwest AL MH/MR Board
- MH Board of Chilton-Shelby
- Cahaba Center for MH/MR
- Calhoun-Celburne MH Board
- East Central MH/MR
- Mountain Lakes
- Spectracare Health Systems
- Montgomery Area MH Authority
- Cullman Area MH Authority
- West AL MH Board
- Western MHC*
- UAB*
- Glenwood*
- Brewer Porch Children's Center*

*Not a 310

Hospitalization
(Downsizing effort for community integration)

Adults

In 1970 Alabama faced a lawsuit, Wyatt vs. Stickney, which brought the "right to treatment" for state psychiatric hospital patients into the foreground. This litigation significantly influenced fundamental changes in architectural features of this States' mental health service delivery system. Upon the filing of the suit, one of the longest running mental health lawsuit in US history, ADMH started shifting focus from providing mental health treatment within the confines of large- scale institutional walls towards creating a new vision and thus, constructing the foundation necessary for community based mental health treatment. The 1999 Olmstead "integration mandate" decision further inspired the pursuit of building more appropriate and effective mental health service models within the community mental health landscape. As ADMH continues pursuing the development and expansion of new and enhanced community supports, great effort and commitment to reflect the desires of consumer partners and to be guided by the voices of those we serve, remain at the core of its design.

ADMH has moved steadily towards less reliance upon state psychiatric inpatient services by shifting funding to less costly, but more effective community services and supports. Since 1971, the census at Bryce alone dropped from over 5,000 patients to less than 400 in 2004. In order to meet the requirements of the Wyatt settlement, ADMH made provisions to utilize a census reduction model in which the care of individuals housed within the States' extended care wards would be transferred to the community provider network. Moreover, strides to better serve consumers outside of inpatient settings continued beyond those prompted by the settlement leading to a statewide reduction in hospital census as well as closures of state operated facilities. Through the dedicated efforts of state psychiatric hospitals and community partners, ADMH can boast nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to present (June 2015).

In 2007, with the establishment of an appointed taskforce, transferring acute care operations from state hospital admission units to the community was the primary focus. Four regional planning groups composed of consumers, family members, mental health centers, state hospital directors, Probate Judges, and private providers, developed "acute care plans" for the establishment of new services. Increased funding in FY07 and FY08 supported the recommendations of the four regional planning groups specifically to reduce use of state psychiatric hospitals as well as to promote system transformation. Whenever possible, local providers work with hospitals to secure local psychiatric inpatient services for indigent consumers. Probate judges can also make involuntary commitments to local inpatient units or residential programs that request and receive 'designated mental health facility' status per the 1991 commitment law. These additions to the service array included purchase of additional local inpatient care, increased psychiatric time, and development of a psychiatric assessment center:

- Inpatient – Twelve centers proposed some type of local inpatient/psychiatric emergency service to increase/enhance local inpatient or acute care services (the Psychiatric Emergency Room proposed for Birmingham was eliminated in FY09 due to budget cuts - it had not opened)
- Residential – 325 new residential beds ranging from apartments to specialized medical homes (24 Supportive Housing units that had not opened were eliminated due to budget cuts)

- Assertive Community Treatment Teams – six new teams
- Community Support Specialists – five positions designed to assist consumers with development of daily living skills
- Adult In-home Intervention Teams – ten new two person teams
- Bridge Teams – two new teams in the Mobile area
- Psychiatric Assessment Center- Montgomery

In 2010, ADMH again pursued the implementation of a census reduction model to address critical overages in state hospitals with a primary focus on Regions 2 and 4. The initial planning for the "Downsizing Project" started during FY09 at which time residents of Bryce and Searcy who were living in Extended Care units or who had a length of stay greater than 90 days were evaluated in order to determine what community services would be needed to promote discharge from the hospital. The evaluation teams were composed of hospital staff, community staff, and advocates. Based on the evaluation and the input of the consumer, community services were proposed to support discharge of these individuals. The planning process continued into FY10 and was incorporated into planning for the sale of Bryce Hospital to the University of Alabama and subsequent construction of a smaller state of the art hospital. Final plans were developed and approved by the Bryce Consumer Transitioning Work Group, the Mental Illness Coordinating Subcommittee, and the Commissioner. Nontraditional financial models were utilized such as incentive and risk barring contracts based on regional outcomes and performance. The community provider network in Regions 2 and 4 established Board of Supervisor groups for the purposes of promoting service coordination and monitoring of project goals at a regional level. New services began in June 2010 in Region 2 (Bryce) and in August 2010 in Region 4 (Searcy).

The plans included the development of the following community services in the Bryce Hospital area (Region 2):

- 84 Supportive Housing Units
- 60 Medication, Observation, and Meals (MOM) beds
- 30 Augmented existing residential beds
- 12 beds in 3 bed group homes
- Peer Bridger Team
- Clinical Support Team
- Flex Funds for Support

The plans for community services in the Searcy area (Region 4) included the following:

- 60 Supportive Housing Units
- 40 Medication, Observation, and Meals (MOM) beds
- 56 Augmented existing residential beds
- 12 beds in 3 bed group homes
- 16 Assisted Living Beds in scattered sites
- Peer Bridger Team
- Flex Funds for Support

In May 2011, the maximum capacity for Bryce's and Searcy's extended care units were formally reduced further underscoring ADMH's commitment to operate smaller inpatient facilities and shift budgetary funds traditionally from state hospitals, to the expansion of services and supports better constructed to promote independence and inclusion into the community for consumers. As a result of the Downsizing Project, there was a reduction of the census at Bryce Hospital by 116 from a FY09 baseline average daily census of 318 to 202, exceeding the target goal of 222; and a reduction in the census at Searcy by 70 from a baseline average daily census of 351 to 245 exceeding the project target of 255.

In the wake of the above described initiatives, the financial atmosphere of FY11/12 and desire to advance a more responsive system of care prompted an acceleration of the Department's goals to further reduce the number of acute care psychiatric beds and to bring about the closure of selected state operated facilities. The 2012 Hospital Closure Project resulted in the Department closures of Greil Memorial Psychiatric Hospital (Montgomery County) August 31, 2012 and Searcy Hospital (Mobile County) October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY11. Over ninety percent of Greil and Searcy's inpatient capacity has been shifted to local communities. As a means of supporting this shift, an innovative framework for processing inpatient commitments was born from the Hospital Closure Project. The dedicated and unprecedented cooperation between state government, local provider agencies, and local probate courts resulted in a new Department of Mental Health Commitment Procedure specifically for Regions 3 and 4 and for which the success of this project hinged. A pivotal element to the newly established commitment procedure was the development of the Gateway System which permits for the tracking of probate committed individuals to be served within the community at a Designated Mental Health Facility or Willing Hospital Participant locales. This process allows for ongoing flexibility, customization, and movement within less restricted levels of care outside of state operated institutions.

The plans included the expansion and/or development of the following community services in the Region 3 area (with closure of Greil Hospital):

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Medication cost provision for indigent population with loss of IDP.
- One ER screening system with partnership between a community mental health center and local hospital.
- Two Crisis Residential treatment facilities (31 beds) to provide psychiatric stabilization treatment in a ADMHF non-hospital setting for either pre/post commitment care.
- Psychiatric access and care
- One probate liaison
- 24 Supportive Housing Units
- 22 Medication, Observation, and Meals (MOM) beds
- 2 Respite beds
- 3 crisis mobile teams

The plans included the expansion and/or development of the following community services in the Region 4 area (with closure of Searcy Hospital):

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.

- Four Crisis Residential treatment facilities (64 beds) to provide psychiatric stabilization treatment in a ADMHF non-hospital setting for either pre/post commitment care.
- Psychiatric access and care
- 60 Supportive Housing Units
- 25 Medication, Observation, and Meals (MOM) beds
- One Centralized Service system with a community mental health center.

During FY13 and FY 14, ADMH pursued similar efforts for Regions 1 and 2 in which the utilization of community inpatient capacity will supplement or supplant acute care functions at North Alabama Regional Hospital (NARH) and Bryce Memorial Hospital respectively. This initiative is referred to as the "Hospital Repurposing Project." In FY12, prior to project implementation, NARH, located in Region 1, served 728 individuals with an acute inpatient bed capacity of 74 and Bryce, located in Region 2, served 897 individuals with an acute and extended care inpatient bed capacity of 268.

The Hospital Repurposing Project proposed plans included the expansion and/or development of the following community services for the following Regions:

Region 1 area:

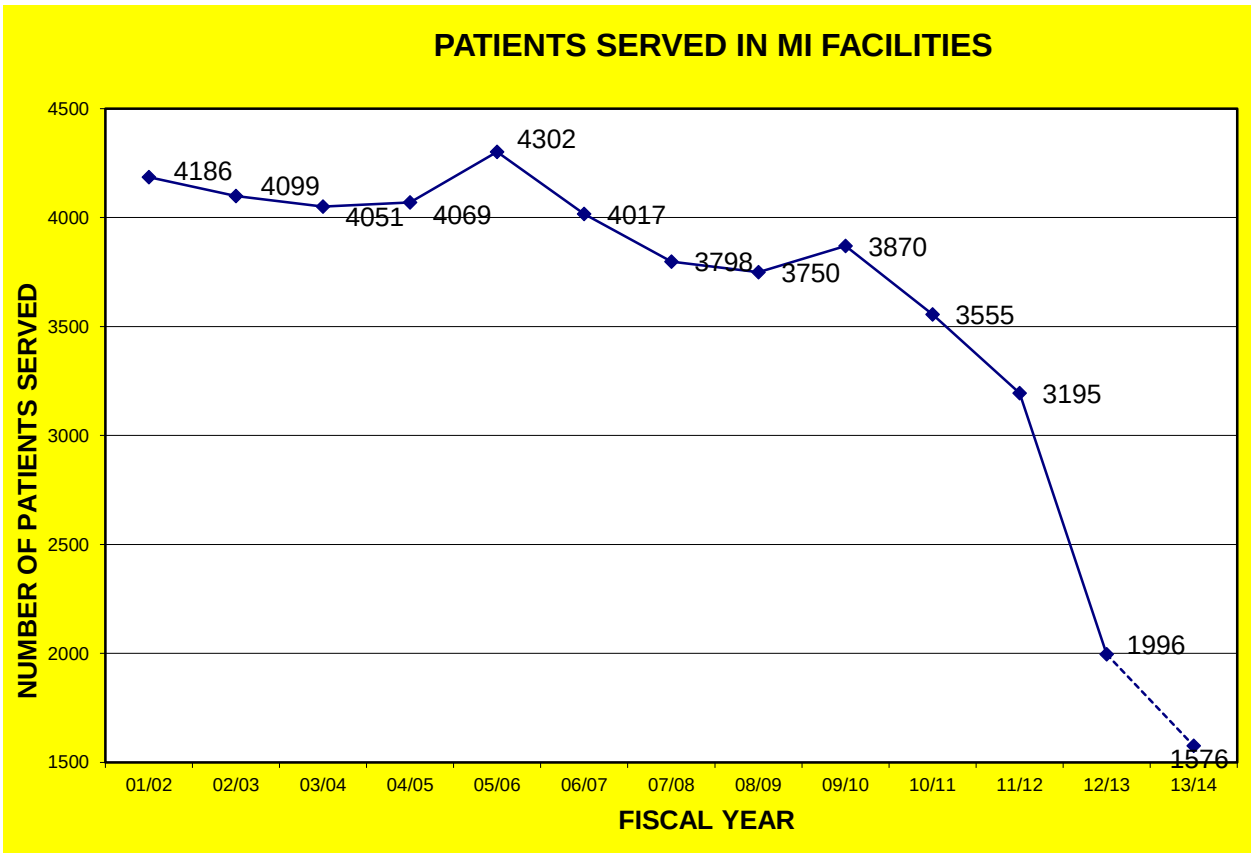
- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Four Crisis Residential treatment facilities (64 beds) to provide psychiatric stabilization treatment in a ADMHF non-hospital setting for either pre/post commitment care.
- One augmented residential care home (12 beds)

Region 2 area:

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Medication cost provision for indigent population with loss of IDP.
- One preventive urgent behavioral health care facility
- 16 beds in a Specialized Medical group home
- 30 beds dedicated to the care of forensic consumers
- 21 beds in 3 bed group homes (15 positioned in Region 1)
- 36 Supportive Housing Units
- 5 crisis mobile teams

On July 20, 2014, patients located at Bryce Psychiatric Hospital were relocated to a new location commonly referred to as the "new Bryce." The facility was constructed with state-of-the-art design and purpose. Hospital wards were reduced in capacity to allow for increased patient privacy and sense of community. In total, the new hospital operates with a 268 bed capacity. During FY15, ADMH was able to attain another significant milestone with the closure of NARH which occurred on June 17th, 2015.

The accumulative effects of statewide efforts to reduce hospital census is generating significant results. The number of patients in residence at end of the year, the number of admissions/readmission, and the total served by state hospitals all show reductions. In FY09, prior to the implementation of the latest series of census reduction projects, the statewide average daily census for all state operated facilities serving adult geriatric, forensic, extended care, and acute care populations totaled 1,054. Compared to this FY09 baseline end of year average daily census, ADMH reduced the total statewide hospital census in FY12 by nearly 24%, in FY13 by 44%, and in FY14 by 50%. ADMH demonstrated nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015.


PATIENTS SERVED IN MI FACILITIES
NUMBER OF PATIENTS SERVED
4500
4000
3500
3000
2500
2000
1500
4186
4099
4051
4069
4302
4017
3798
3750
3870
3555
3195
1996
1576
01/02
02/03
03/04
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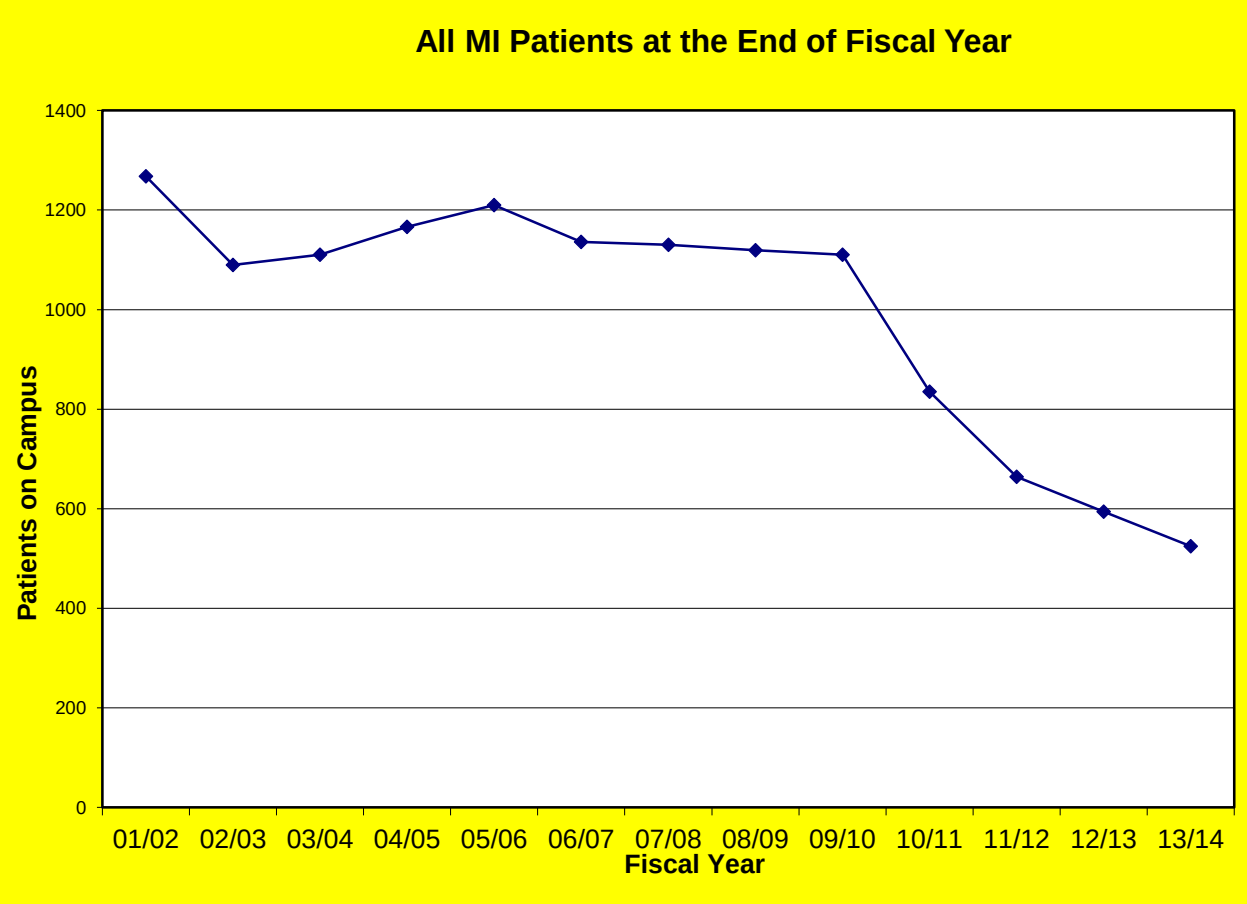
07/08
08/09
09/10
10/11
11/12
12/13
13/14
FISCAL YEAR


All MI Patients at the End of Fiscal Year
Patients on Campus
1400
1200
1000
800
600
400
200
0
01/02
02/03
03/04
04/05
05/06
06/07
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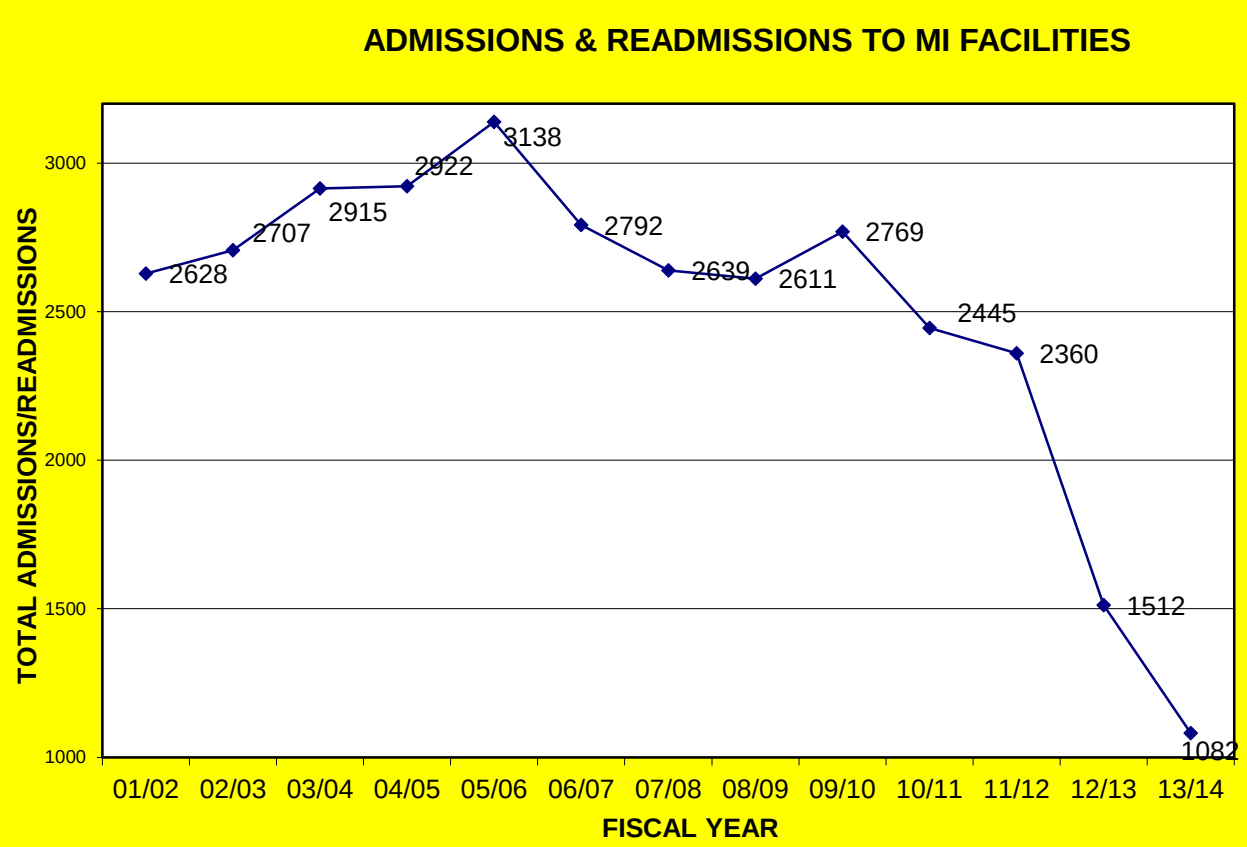
11/12
12/13
13/14
Fiscal Year

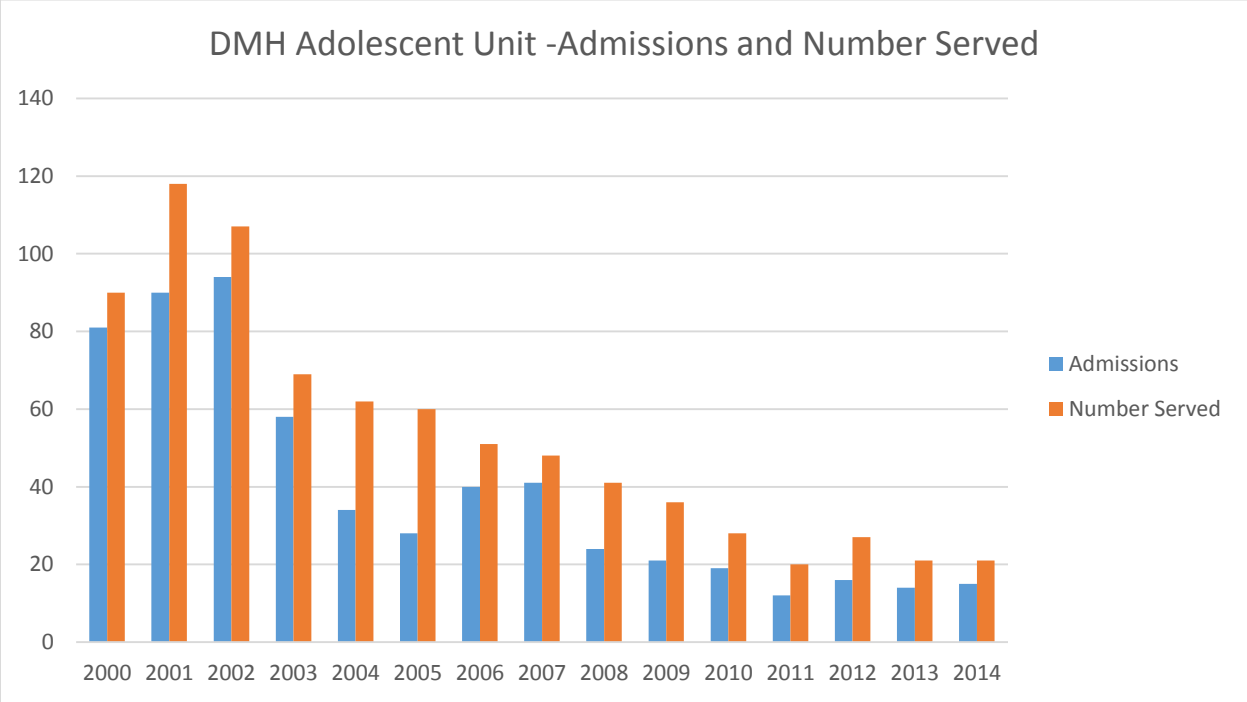


ADOLESCENTS

In regard to adolescents, the inpatient beds operated by the Mental Health system in Alabama for adolescents were located at Bryce State Hospital Adolescent Unit serving the state's child and adolescent population. In March of 2004, the original 40 bed unit for adolescents at Bryce Hospital was reduced to a 20 bed unit. While this reduction was in part a cost saving measure, it was possible because of the significant census reduction experienced by the unit. A total of 19 adolescents were admitted and 28 served at the Adolescent Unit at Bryce Hospital during FY10. This number represented a decrease in total number admitted and in total number served from the previous years. The unit remained below capacity. The ability to keep census below capacity is attributed to the expansion of community services and the development of a service referred to as a Juvenile Court Liaison. Juvenile Court Liaisons work closely with the state child and adolescent services staff, with the sole mission of appropriately diverting mental health and juvenile court commitments in lieu of more appropriate community based services. Children or adolescents are not placed in out-of-state programs by ADMH, Division of Mental Illness and Substance Abuse Services.

During the FY09 legislative session, an amendment to the Juvenile Code was signed by the Governor in May 2009 that affirmed the ADMH Commissioner's ability to designate a hospital/facility outside of the Department to provide services to minors and children with SMI or intellectual disabilities and to place these minors and children who have been committed to the Department in said hospital/facility. These changes were in line with the recommendations of the Child and Adolescent Workgroup of the Systems

Reconfiguration Task Force. A contract transferring the operation of the ADMH Psychiatric Adolescent Unit from Bryce Hospital into a smaller (10 bed) unit at the University of Alabama in Birmingham Department of Psychiatry and Behavioral Neurobiology was signed. The transfer was effective in October, 2010. Since moving into the new location at UAB, the unit has continued to remain at or near capacity most of the time, even though the number of beds is half of that at the Bryce Adolescent Unit. This has been due to continued success in expanding and improving access to less-restrictive community-based treatment options for children and adolescents, and continued effective collaboration between child-serving agencies at the state and local level.



Community Based Mental Health Services

The services eligible for reimbursement for the adults who are severely mentally Ill (SMI) and children and adolescents who are severely emotionally disturbed (SED) throughout the state, via contractual relationships between the Department and the 310 Boards, are shown below. Many of these service categories apply to both adult and child populations. The contract eligibility criteria specify that funds should be used to serve individuals who cannot afford to pay, are not insured, and who meet the criteria for Serious Mental Illness and Severe Emotional Disturbance as well as those individuals presenting in an emergency situation.

Mental Illness Ambulatory Services

1. *Intake/Evaluation*
2. *Diagnostic Testing*
3. *Individual Counseling or Psychotherapy*

4. *Group Counseling or Psychotherapy*
5. *Family Counseling or Psychotherapy*
6. *Crisis Intervention and Resolution*
7. *Pre-Hospitalization Screening/Court Screening*
8. *Physician/Medical Assessment and Treatment (to include telemedicine)*
9. *Medication Administration*
10. *Medication Monitoring (Non-Physician)*
11. *Partial Hospitalization Program (adults only)*
12. *Adult Intensive Day Treatment*
13. *Adult Rehabilitative Day Program*
14. *Child and Adolescent Mental Illness Day Treatment*
15. *Adult In-Home Intervention*
16. *Child and Adolescent In-Home Intervention*
17. *Assertive Community Treatment (ACT) (adults only)*
18. *Program for Assertive Community Treatment (PACT) (adults only)*
19. *Mental Illness Basic Living Skills*
20. *Family Support Education*
21. *Treatment Plan Review*
22. *Mental Health Consultation*

Case Management Services

23. *Case Management*

Residential

24. *Adult Small Capacity (3 bedroom) Residential Care Home*
25. *Adult Residential Care Home*
26. *Adult Residential Care Home with Specialized Basic Services*
27. *Adult Residential Care Home with Specialized Medical Services*
28. *Adult Residential Care Home with Specialized Behavioral Services*
29. *Adult Therapeutic Group Home*
30. *Intermediate Care Program (adults only)*
31. *Crisis Residential Program (adults only)*
32. *Psychiatric Assessment Center (adults only)*

33. *Child/ Adolescent Residential Care Program*
34. *Child/ Adolescent Residential Care Program – Intensive*
35. *Child/ Adolescent Diagnostic and Evaluation Residential Care Program*
36. *Transitional Age Residential Care Program*
37. *Medication/Observation/Meals (MOM) Program (adults only)*

Minimum Continuum of Care

Expectations for providing minimum continuum of care services for a community mental health provider or a community mental health center is outlined fully in the Alabama Department of Mental Health Mental Illness Community Programs within the Administrative Code – Chapter 580-2-9, Program Standards. A provider that meets the respective requirements will be issued one of two types of certificates depending upon the number and type of services delivered by the provider.

(a) **Mental Health Services Provider** – A provider may be certified as a Mental Health Services provider if it provides one or more (but not all) of the services as listed below in compliance with the ADMH standards.

- General Outpatient
- Child and Adolescent In-Home Intervention
- Adult In-Home Intervention
- Emergency Services
- Partial Hospitalization Program
- Adult Intensive Day Treatment
- Adult Rehabilitative Day Program
- Child and Adolescent Day Treatment
- Case Management
- Residential Services
- Designated Mental Health Facility
- Consultation And Education
- Assertive Community Treatment
- Program for Assertive Community Treatment
- Child and Adolescent Seclusion and Restraint
- Adult Seclusion and Restraint
- Therapeutic Individualized Rehabilitation Services

(b) **Community Mental Health Center** – A provider will be certified as a Community Mental Health Center (CMHC) if the requirements listed below are met. The requirements are designed to assure that any provider certified as a CMHC provides the array of services defined below either directly or through specific arrangement with another agency/individual to a broad array of recipients in an identified service area without regard to age, race, language of preference, sex, and degree of psychiatric disability. The services must be coordinated in a manner that assures access to inpatient and residential care and to community supports for adults with serious mental illness and children and adolescents severe emotional disturbance.

The provider must provide the following services directly through its employees. In addition to the specific criteria listed below, the provider must also comply with the applicable sections of the program standards for each program element.

- Emergency Services.
- Outpatient Services (to include specialty services for children and elderly),
- Consultation and Education Services,
- Specialty services for persons discharged from an inpatient psychiatric setting and for persons with a serious mental illness/severe emotional disturbance and must include the following:
    - Evaluation and medication monitoring by a psychiatrist.
    - Outreach capability to provide services to consumers in their usual living situation.
    - Provision of case management services in accordance with the program standards either directly or through an arrangement approved by the Alabama Department of Mental Health.
    - Screening for admission to state psychiatric hospitals as evidenced by a written agreement with the local 310 Board (if not a 310 Board), relative to coordination of screening petitions for involuntary inpatient commitment for consumers of the CMHC.
- Partial Hospitalization/Intensive Day Treatment/ Rehabilitative Day Program, **and**
- Must provide residential services either directly through its employees or through agreement with other certified providers.

Because Community Mental Health Centers are expected to offer a broad array of services to a demographically and psychiatrically diverse population, the following additional requirements regarding the overall operation of the agency must be met:

- Staff capable of providing specialty outpatient services to children, adolescents, adults, and older adults.
- Should be able to demonstrate community outreach efforts designed to promote access from all age groups with particular emphasis on those who are seriously mentally ill or severely emotionally disturbed.
- The number of recipients both total and by service type and the services provided are acceptable for the time period that the agency has been operational and are roughly proportionate to the number of consumers and types of services provided by agencies similarly certified.
- The provider can demonstrate appropriate response to consumers for whom a petition for involuntary commitment has been issued and/or who have been hospitalized at a state psychiatric hospital.
- At the end of the first year of operation, the agency must have served at least 100 consumers and the services provided should be proportionate to the average of those agencies that are similarly certified.

Child and Adolescent Development of Continuum of Care

The Levels approach to a minimum continuum of care for mental health services delineated in 1985 by the Alabama CASSP Definition Committee and revised in 1998 and 2004 by the Strategic Plan Workgroup provides a sound framework for prioritizing service development and expansion. The structure (by delineating statewide, regional, and local levels) intends to strike a realistic balance between a minimal service set, economy of scale, and fiscal reality. It is assumed that

ADMH, in conjunction with the community mental health centers, will not necessarily create and/or operate the total system, but will exhibit the leadership necessary to assure development, effective operation, and coordination. The continuum as envisioned is as follows:

Level I: (Community/County-Based)

Diagnosis and Evaluation (screening)

Outpatient (Individual, Group, Family)

Family Support (Consultation, education, training, networking to build a support system)

Level II: (Community/Catchment Area-Based)

Diagnosis and Evaluation (comprehensive)

Case Management

Day Treatment

Respite Care

In-Home Intervention

Behavioral Aide

Child and Adolescent Psychiatric Services

Level III: (Regional/Shared)

Respite Care Beds

Crisis Residential

Residential Treatment

Acute Hospitalization

Level IV: (Statewide)

Short Term Treatment and Evaluation Program (STTEP)

ADMH Psychiatric Adolescent Unit at UAB

Mental Health and Rehabilitation Services

Alabama continues to develop a comprehensive system of care for children and adolescents with serious emotional disturbances that extend across the state. In addition to the main offices in the 24 community mental health centers, services are available in most of the state's 67 counties through the satellite programs of the CMHCs. The services available vary across the catchment areas (See table below).

2015 Alabama C&A MI Programs by County (8/25/2015)												
PROVIDER	**Out-patient**	**JCL**	**Case Mgt**	**In-Home**	**Day Tx**	**Respite**	**Tele-med**	**Resid**	**SBMH Collab**	**Youth Peer Spt Spec**	**Family Peer Spt Spec**	**Crisis**
AltaPointe	---	---	---	---	---	---	---	---	---	---	---	---
Mobile	X	X	X	X	C/A/SC/SA	X	X	X	X			X
Washington	X	X					X		X			X
Baldwin	X	X	X	X	C/A/SC				X			X
Brewer-Porch	X				C			X				X
Cahaba MHC	---	---	---	---	---	---	---	---	---	---	---	---
Dallas	X	X	X	X			X		X			X
Perry	X	X										X
Wilcox	X	X	X									X
Calhoun-Cleburne	---	---	---	---	---	---	---	---	---	---	---	---
Calhoun	X	X	X	X	C		X		X			X
Cleburne	X	X	X						X			X
Cheaha MHC	---	---	---	---	---	---	---	---	---	---	---	---
Clay	X	X	X	X			X					X
Coosa	X	X	X									X
Randolph	X	X	X				X					X
Talladega	X	X	X				X					X
CED MHC	---	---	---	---	---	---	---	---	---	---	---	---
Cherokee	X	X	X									X
Etowah	X	X	X	X	SP				X			X
Dekalb	X	X	X						X			X

PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
Chilton-Shelby MHC	---	---	---	---	---	---	---	---	---	---	---	---
Chilton	X	X	X									X
Shelby	X	X	X	X	C (x2)/SC				X			X
Cullman MHC	X	X	X	X	SC		X		X			X
East Alabama MHC	---	---	---	---	---	---	---	---	---	---	---	---
Chambers	X	X	X						X			X
Lee	X	X	X	X	AC/SC	X	X		X			X
Russell	X	X	X				X		X			X
Tallapoosa	X	X	X				X		X			X
East Central MHC	---	---	---	---	---	---	---	---	---	---	---	---
Bullock	X	X	X								X	X
Macon	X	X	X								X	X
Pike	X	X	X	X		X	X				X	X
Eastside MHC	X						X		X			
Gateway	X				X							
Glenwood MH	X							X				
Indian Rivers MHC	---	---	---	---	---	---	---	---	---	---	---	---
Bibb	X	X	X				X					X
Pickens	X	X					X					X
Tuscaloosa	X	X	X	X			X					X
J-B-S MHA	X	X	X	X		X				X	x	X
MHC of Madison Co.	X	X	X	X	P/SC				X			X

PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
Montgomery Area	---	---	---	---	---	---	---	---	---	---	---	---
Autauga	X	X	X	X			X		X			X
Elmore	X	X	X	X			X					X
Lowndes	X	X	X	X			X					X
Montgomery	X	X	X	X					X			X
Mountain Lakes	---	---	---	---	---	---	---	---	---	---	---	---
Jackson	X	X	X	X	AC/SC							X
Marshall	X	X	X	X					X			X
North Central MHC	---	---	---	---	---	---	---	---	---	---	---	---
Lawrence	X	X	X		P/SP/SC/ SA		X					X
Limestone	X	X	X	X	SC/SA		X					X
Morgan	X	X	X	X	SC/SA		X					X
Northwest MHC	---	---	---	---	---	---	---	---	---	---	---	---
Fayette	X	X	X		P/AC (x2)		X					X
Lamar	X	X	X		P/AC (x2)		X					X
Marion	X	X	X		P/AC		X					X
Walker	X	X	X		P/C/A		X					X
Winston	X	X	X		P		X					X
Riverbend MHC	---	---	---	---	---	---	---	---	---	---	---	---
Colbert	X	X	X	X	SC/SA				X			X
Franklin	X	X	X	X	SC/SA				X			X
Lauderdale	X	X	X	X	P/SC/SA				X			X

PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
South Central MHC	---	---	---	---	---	---	---	---	---	---	---	---
Butler	X	X	X	X			X		X			X
Coffee	X	X	X	X					X			X
Covington	X	X	X	X					X			X
Crenshaw	X	X	X	X								X
Southwest MHC	---	---	---	---	---	---	---	---	---	---	---	---
Clarke	X	X	X				X					X
Conecuh	X	X	X	X			X					X
Escambia	X	X	X	X			X		X			X
Monroe	X	X	X				X					X
SpectraCare MHC	---	---	---	---	---	---	---	---	---	---	---	---
Barbour	X	X										X
Dale	X	X	X									X
Geneva	X	X										X
Henry	X	X	X									X
Houston	X	X	X	X			X		X			X
UAB MHC	X				P/C/A/SP/SA							X
West Alabama MHC	---	---	---	---	---	---	---	---	---	---	---	---
Choctaw	X	X					X					X
Green	X	X					X					X
Hale	X	X					X					X
Marengo	X	X	X				X					X
Sumter	X	X	X				X					X
Western MHC	X											X

Abbreviations		
Outpatient - Individual/Family Therapy	Day Tx – Day Treatment	SP-Summer Preschool
JCL – Juvenile Court Liaison	P – Preschool	SC-Summer Child
Case Mgt – MI Case Management	C – Child	SA-Summer Adolescent
In-Home – In-Home Intervention Team	A – Adolescent	AC-After School DTx Child
Telemed. – Telemedicine	Resid – MI Residential	SBMH Collab-School-Based Mental Health Collaboration
Youth Peer Spt Spec-Youth Peer Support Specialist		Family Peer Spt Spec-Family Peer Support Specialist
--- For Informational Use Only ---		

Case Management

Through the implementation and evaluation of two federal Community Support Program (CSP) grants which provided brokerage type case management services to adults who were seriously mentally ill (1983), and adults who were homeless and seriously mentally ill (1987), and an Office of Substance Abuse Program (OSAP) local demonstration grant which focused on case management to children and adolescents with serious emotional disturbances (1987), the Alabama ADMH was ready in FY88 to begin statewide implementation of case management services. The demonstration grants provided expertise and techniques to organize and deliver effective case management services, as well as staff with the training skills to disseminate the service statewide.

Two events converged to give impetus to the development of case management services in FY88. One was the funding of a CSP systems development grant which provided funding support for training 100 new case managers in the state. The other critical event was the addition of the Targeted Case Management Option to the Alabama Medicaid Plan beginning on October l, 1988. Optional Targeted Case Management provided a new funding source specifically for services to adults who are seriously mentally ill (SMI), and children and adolescents who have serious emotional disorder (SED).

The mental health centers work with a variety of public and private resources to obtain services and supports needed by SMI and SED consumers in the community. Case Management services are essential to successful maintenance of persons who have SMI and SED in the community. Adult case managers and supervisors are trained either locally through an approved training curriculum or at training sessions provided by Jefferson-Blount-St. Clair Mental Health/Mental Retardation Authority (JBS). All Child and Adolescent case managers and their supervisors are trained through an approved training curriculum provided by JBS. In addition to mastering material specific to adults with serious mental illness and children and adolescents with serious emotional disturbances, trainees must also complete a module required by Medicaid for all case managers. These sessions held by JBS, to include C&A In-Home Intervention, occur about every two months. The certification standards require successful completion of this training prior to provision of services, with additional one day training on legal issues and psychotropic medications necessary to be fully certified in C&A case management. In FY14, 10,118 adults and 3,986

children and adolescents had received case management services. Every community mental health center has case management services for adults and children and adolescents.

Children and adolescents with serious emotional disturbances are provided case management services in several ways in the state. First, there are Family Integration Network Development (FIND) projects, now referred to as In-Home Intervention (IHI), currently operating in twenty of the state's twenty-two mental health regions, which include dedicated case managers and two-person in-home intervention teams. At present, there are 51 C&A In-Home intervention teams. The in-home teams also provide case management services as part of their 12-week intervention. At present, every community mental health center catchment area has a least one designated children's case manager. Children and adolescents may also receive case management from qualified CMHC staff who has been cross-trained in the delivery of case management to both adults and youth.

RESIDENTIAL CARE

Adult community residential is a key service within the continuum of care. Residential services support discharges and diversions from state psychiatric hospitals. The table below shows the current availability of residential treatment and housing programs listed on the Mental Illness Community Residential Placement System (MICRS) by community service area and by type of program. Overall, residential slots have increased from 1,253 in FY1991 to 2,771 units to date.

Community Residential Beds
July 2015

CMHC	THOME	RCH	RCSPEC	CRISIS	SEMINT/ SHOUS	MOM	FOSTER	INTMD CARE	3 BED	EBP SHP	TOTAL
Baldwin											0
Cahaba	12		26		33		8		3		82
Cal-Cleb			14	16	16				3		49
CED	20						73			12	105
Cheaha	15				46		6			12	79
Chil-Shel			40							36	76
Cullman				16	27						43
East Al			30	11	17		2				60
East C		14	60	15			11				100
Huntsville		22		26	69		33		3	12	165
Indian Rivers		17	16	10	52	20	5		3	12	135
JBS	30	10	80		81	92	44		21	36	394
Mt. Lakes		12			8		49		3	12	84
Altapointe		14	182		102		99	32	15	60	504
Montgomery	10		54	32	55	12	10		3	12	188
North C		34				20					54
Northwest			113	16	66				3		198
Riverbend			16		39	11			9		75
South C			10					16	3	24	53
Southwest			14			25				24	63
Spectracare		32	48				27	16		60	183
West Al			26		43					12	81
TOTAL	87	155	729	142	654	180	367	64	69	324	2771

THOME = Therapeutic Group Home, RCH = Residential Care Home, RCSPEC = Residential Care Home with Specialized Services, CRISIS = Crisis Residential, SEMINT= Semi-independent living with intensive supervision, SPHOUS = Supported Housing, FOSTER = Foster Care Facility, INTMD= Intermediate Care, MOM=Medication, Observation, and Meals, EBP SHP= Permanent Supportive Housing

This list represents the number of housing units for seriously mentally ill adults that are provided by community mental health centers (CMHC) or are under contract with CMHCs. It is important to note that there are also numerous individuals who reside in housing supported with Section 8 Rental Assistance and Alabama Housing Finance Authority units, nursing home beds, and assisted living facility beds which are not operated by community mental health centers and, thus, are not captured in the above chart. In FY 13 and in FY14, 362 and 322 individuals, respectively, were residing in nursing homes under contract with the local community mental health center via subcontract with the ADMH. Also, a small pilot program initiated in FY07 to purchase local Assisted Living Facility (ALF) for individuals being placed out of the state geriatric psychiatric hospital was expanded in FY12. The ALF project served 28 individuals in FY13 and 27 in FY14.

For Children and Adolescents, residential services do not exist in all catchment areas. However, there is access statewide to the following components:

Short Term Treatment and Evaluation Program

A 10 bed short-term treatment and evaluation program fills gaps in the service system for comprehensive evaluation outside of inpatient psychiatric hospitals. STTEP offers comprehensive diagnostic and evaluation services and short-term (7-90 days) residential treatment to the statewide population of children and adolescents, ages 5-12 years, with a serious emotional disturbance. This program is jointly funded by the Department of Mental Health (ADMH) and the Department of Human Resources (DHR).

Children's Residential Treatment

Two intensive residential programs, located in Birmingham, serves children with serious emotional disturbances from across the state, ages six through fourteen. Contract beds are jointly funded by the ADMH and DHR. An intensive residential program located in Mobile has 8 contract ADMH beds and serves children and adolescents with serious emotional disturbances from across the state. A transitional age residential program, located in Mobile, serves consumers age 17-22. The 10 contract ADMH bed group home has as its priority population young adults who currently need transitional placement from the state hospitals.

SUPPORT SERVICES

As described earlier, a comprehensive system of community mental health services is being developed for adults with serious mental illness and children and adolescents with serious emotional disturbances. The primary mental health service that ties consumers to other needed services is case management. Case managers, through their assessment of consumer needs, development of comprehensive service plans, and linkage of consumers to needed services through referral, active assistance and advocacy, and monitoring of service utilization, are responsible for assuring access to the broad range of needed community services.

Consumer outcome research conducted as part of the program evaluations of demonstration case management programs for adult SMI, homeless SMI, and SED children and adolescents in the state have

all found case managers to be successful in significantly increasing the use of the broad range of services needed by consumers. Research results also suggest that the level of functioning of consumers increased with the increased use of services. These outcomes suggest that increased participation in a variety of needed services not only improve the quality of life of consumers, but can also increase the adaptive functioning of consumers in areas of everyday life that are critical to their community tenure. The following are the types of housing, health, rehabilitation, employment, education, medical, dental, and support services that, in addition to mental health services described earlier, are needed in order for consumers to function in their home communities.

Housing Services

Housing is one of the State's critical gaps. It is the Department's hope that "all services will be provided from a person-centered treatment planning perspective driven by family and consumer needs and that consumers will receive not only high quality treatment services, but will receive the necessary supports to achieve the highest degree possible of independent living in safe and decent housing, to be employed, and to engage in social interaction with friends and family."

Alabama is the sixth poorest state in the nation (July 11, 2015 Montgomery Advertiser) with a population of 4.8 million (2014 Census estimate), 18.9% live below the federal poverty level**.** The availability of safe and affordable housing remains a challenge for consumers with mental illness and limited or no income. According to the National Low Income Housing Coalition 2014 State Housing Profile, Alabama has a shortage of over 90,000 available and affordable homes for extremely low income earners and 72% of them spend more than half of their income on housing alone. Nearly 1 in 6 Alabamians live below the federal poverty line as cited in the Poverty and Shared Households by State: 2011 American Community Survey Briefs. Moreover, if an Alabama resident's sole income is SSI in the amount of $698 per month, then 81% would be required to afford a 1-bedroom apartment at Fair Market Rent as reported in Priced Out in 2012: The Housing Crisis for People with Disabilities. The 2014 Out of Reach report states that about 8.3 million individuals receive SSI nationwide because they are elderly, blind, or have another disability, and have few other economic resources.

Governor Robert Bentley assumed office January 2011. In February 2011, he announced the creation of Hardest Hit Alabama (HHA), a new program providing $162 million to the Alabama Housing Finance Authority to provide targeted assistance for Alabama's unemployed homeowners for the prevention of foreclosures. This program is considered an important step in the prevention of homelessness due to widespread unemployment and risk of foreclosures in Alabama.

October 2012, ALHousingSearch, Alabama's premier housing locator service, was launched leading to multiple demonstrations of this new statewide resource created to help people list and find safe, decent, and affordable and accessible housing, in addition to emergency housing across the state. This web based service, supported by a toll-free call center, provides information for the general public as well as for housing professionals seeking vital resources for their clients. This project was initially funded by the Alabama Council on Developmental Disabilities, but is now supported with Alabama Department of Mental Health funds

The Department holds Board and general membership to the Low Income Housing Coalition of Alabama (LIHCA), which is a statewide coalition consisting of housing advocates, elected officials, banking institutions, nonprofit service providers, legal services groups, and low income persons and whose mission is to increase housing opportunities for individuals with the greatest financial need. The Low Income

Housing Coalition of Alabama (LICHA) observed that Alabama has historically relied solely on federal funding for the development of affordable housing and that public funding is critical for the future development of affordable housing. LIHCA advocated for passage of the National Housing Trust Fund and campaigned for the establishment of an Alabama Housing Trust Fund. LIHCA released **LIHCA's 2014 Red Book** which includes a series of county housing profiles identifying housing affordability, housing availability, number or homeowners/renters, available housing units and various community, household, and special needs factors. The special needs category includes the number of individuals living with a disability, HIV/AIDs, and serious mental illness.

In May 2012, Governor Bentley signed into law House Bill 110 (HB 110) which established a state housing trust fund. This trust fund is meant to be a flexible source of funding for use in developing and maintaining safe and decent rental and ownership options for families, elderly, persons with disabilities, and others who cannot afford housing. Alabama is one of six states to have created housing trust funds legislatively but do not currently have public revenues committed to the funds.

The Housing Advisory Council (HAC), established by the Department's Office of MI Community Programs, is made up of housing stakeholder and advocacy group representatives. This Council serves as an advisory body around the areas of housing and strategies for development. Through a NAMI-Alabama contract and in collaboration with HAC, a housing needs assessment was conducted in 2007 and a statewide supportive housing plan was developed through the efforts of two expert housing consultants. Using gaps analysis, 8600 units of temporary and permanent housing were projected to be needed. As a result, a Supportive Housing Plan was developed and clearly laid out objectives and guiding principles. In 2011, this plan was revised with the goal to establish housing necessary to support consumers living successfully in the community and to realize the Department's plan for reducing inpatient census by closing facilities and transitioning consumers from state facilities and from community group homes to more integrated settings. In continued recognition of the importance of housing as an essential part of treatment and recent hospital closures, an updated Housing Needs Assessment has been completed in which the 2015 update to the ADMH Supportive Housing Plan is currently in draft form. Using gaps analysis with current data reflects an estimated need for 11,442 supportive housing units.

Given the issues related to stigma and limited housing options available for citizens with serious mental illness, especially those with limited or no income transitioning from institutions or from homelessness, the Department has historically relied on expanding housing programs within its' own continuum of care in an attempt to meet this need. Currently, the Department contracts roughly 49.6 million dollars with the community mental health provider network to provide approximately 2,772 beds for various living arrangements for adults such as group homes, semi-independent apartments and supportive housing. A preliminary comparison of 2007 and 2013 data listed in MICRS, reveals significant changes in the number and type of community living alternatives for persons with mental illness to include those who are homeless. Although some types of housing programs historically used within the mental health continuum, such as foster homes and therapeutic group homes, have decreased, overall housing programs have increased by 35.6%. This represents an increase in 750 community beds of various types. Most notably, evidence based permanent supportive housing, first adopted in 2007, has increased significantly To date, there are 324 permanent supportive housing units in operation consistent with the evidence based model. The original 108 pilot units are directly supported by ADMH funds. The remaining numbers of units are supported by "bridge funds" obtained from the 2009 downsizing project and, most recently, the hospital closure project in which funds used to support hospitals were transferred to expand

community services. Even with this effort, housing opportunities fall short of the projected numbers estimated to meet the needs of our consumer populations.

Additionally, the Department continues to maintain $250,000 Housing Support Funds, available statewide for mental health providers to use in order to assist consumers with obtaining and maintaining more independent and stable housing.

Alabama participated as a pilot site for SAMHSA's Permanent Supportive Housing Toolkit and provided training around supportive housing principles. To date, there are 324 permanent supportive housing units in operation consistent with the evidence based model. The original 108 pilot units are directly supported by ADMH funds. The remaining numbers of units are supported by "bridge funds" obtained from the 2009 downsizing project and, most recently, the hospital closure project in which funds used to support hospitals were transferred to expand community services.

The Department continues a partnership with the Alabama Housing Finance Authority (AHFA) to focus attention on the housing needs of persons the Department serves. AHFA established HOME and Low Income Tax Credit 490 set-aside units with reduced rental rates. Housing is also available at reduced rental rates through USDA Farmers Home developments. A Housing Advocate employed by the Department, works to ensure that priority for vacancies as they develop are given to individuals with serious mental illness, developmental disabilities, or substance abuse disorders.

HUD has remained a dedicated supporter to the Department in an effort to expand housing options for the individuals we serve. In 2011, upon hearing of the plan to close state facilities, the Alabama HUD Field Office located in Birmingham, of which Michael German is the Director, graciously extended an offer to assist the Department in efforts to transition persons from institutions. As a result, a series of meetings transpired with key leadership from HUD, Fair Housing, and Public Housing Authorities. In March 2012, the Department participated in HUD's Community Planning and Development Statewide panel discussion as a first step of many to create a framework from which to build collaborations at a local level as well as state level. Ongoing efforts include identifying cohort populations within state institutions and those living in congregate settings who, with adequate supports and access to affordable housing options, could move to more integrated settings. HUD is leading an effort to identify vacancies in set-aside units and other housing projects within their continuum available for which individuals with disabilities would qualify.

ADMH is the grantee for two HUD Shelter plus Care grants, the first of which has been longstanding within the urban area of Mobile. The most recent annual performance report for Mobile demonstrated a 44 homeless individuals were served. In 2011, the Department was awarded rural based Shelter plus Care grant allowing four mental health providers to expand housing in their rural service area. The most recent annual performance report for this project demonstrated 27 individuals were served

LICHA is sponsored by Collaborative Solutions, Inc. (CSI), an approved technical assistance consultant of the Alabama HUD Field Office. The Department has partnered with CSI to pursue Rural Housing and Economic Development (RHED) grants. CSI is the state lead for Rural Supportive Housing Initiative (RSHI) striving to establish Peer Networks linking emerging community-based organizations interested in the provision of supportive housing with experienced supportive housing developers. Through this Peer Network, CSI provides the leadership, support, and training necessary to help providers address the affordable housing challenges in their communities.

As part of the overall Housing initiative, it is anticipated that a small number of housing units may be identified and developed to assist with transition services from child and adolescent services to adult services (17-22 years of age). Due to the unique developmental, social, and educational/vocational needs of the 17–22 year old consumer population, it makes sense to offer residential services that are designed to address these needs programmatically.

ADMH service delivery system recognizes adults at 18 years of age. A consumer is eligible for all adult services if they also meet the SMI criteria. At present, there is a gap in the service delivery system around residential and day treatment needs. This appears to be not one of eligibility on the part of the young consumer, but rather a perceived inappropriateness based on the developmental issues of each consumer population. This transitional population (17 – 22) presents with additional challenges in regards to legal status. Often these consumers may be under the jurisdiction of a juvenile court until they are 21, or in the legal custody of the Department of Human Resources. System wide accommodation will take some time. Until then, consumers who have needs greater than outpatient and case management are handled on an individual basis.

The Department acknowledges the lack of adequate affordable housing stock for Alabama residents and the need for a statewide policy and strategy to address this issue. ADMH representatives will continue to work in all venues to access new housing resources for individuals we serve.

Transitional Age Service

An emerging issue for child and adolescent mental health services is the unique unmet needs of those adolescents transitioning from the child mental health system and entering the very different adult mental health system. In an effort to better address these needs, a work group was developed by the Child and Adolescent Task Force, which includes adult advocates and mental health professional and planners from adult services. . In FY07, recommendations were made by this workgroup, adopted by the Child and Adolescent Task Force, and approved by the Mental Illness Coordinating Sub-Committee to RFP for a Transitional Age Group Home, a Transitional Age In-Home team, and a Transitional Age Case Manager, all within a Pilot Demonstration Site. These services are to be operational by fall 2008. The workgroup continued its efforts on the development of parameters for the Transitional Age Supporting Housing Model and other outpatient/community based Transitional services. In FY09, due to budget cuts, the Transitional Age Supported Housing project lost its funding. Data is being collected on the programs. Also, based on these models, the information was utilized to develop standards around Transitional Age Residential and standards were incorporated in the revised MI Certification Standards that became effective in October 2010.

Outreach to Homeless Individuals

ADMH is a recipient of the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program for which it was most recently awarded $605,830.in funds allocated to support five community mental health providers located in the most metropolitan areas which reflect the highest homeless point in time counts within the state. PATH funds are the only source of dedicated funding specifically targeted to serving homeless individuals who are seriously mentally ill and/or have a co-occurring disorder. The Department proposes to contact 1,105 individuals in FY15 through outreach efforts.

In 2014, The Department served a total of 93,896 people statewide through community programs. Of that number 65,615 were adults and 28,281 were children and adolescents. Of the total population

served, 1,127 of people presented as living in a shelter or as homeless at time of admission to community mental health services. The highest concentrations of these individuals were located in the most populated areas of the state with the Birmingham area comprising 37% of the statewide total adults receiving community mental health services. In less populous regions of the state not receiving PATH funds, regular case management is offered to those who are homeless and have a serious mental illness and/or co-occurring disorder.

The Department remains committed to supporting all plans for addressing homelessness and for increasing affordable housing opportunities and understands system wide partnerships are necessary to effectively end homelessness in Alabama. Since Bentley assumed office, the Governor's Statewide Interagency Council established under Executive Order #31 signed in 2005 under previous administration, has remained inactive. The Alabama Alliance to End Homelessness (ALAEH) steadfastly pursued Executive Order (#43) for the purposes of reestablishing an organized statewide effort in the areas of homelessness and housing. The draft order articulated the hope that "the prior Governor's Statewide Interagency Council would be reestablished as the new *Governor's Statewide Commission on Homelessness & Housing ("the Commission")* for the purpose of serving as a planning and policy development resource for the Governor, the State and its various departments and agencies, and for the private sector specifically for issues related to homelessness and housing relative to issues of prevention of homelessness and rapid re-housing in Alabama…" Upon the establishment of the Commission, the 2007 Blueprint towards a Ten-Year Plan to End Homelessness in Alabama would be revisited. However, due to a limited resources, the Governor's office is unable to support Executive Order #43. The Governor's Director and Deputy Director of ServeAlabama proposed establishing active representation of ServeAlabama at ALAEH Board Meetings. ALAEH Bylaws are currently under review for inclusion of Governor's Office representation.

The Department is supportive of all 8 instate Continua of Care in Alabama. Continua stationed in Montgomery, Mobile, and Birmingham have published local plans to address homelessness and are in various stages of implementation. The State PATH contact serves on the Boards for the Alabama Rural Coalition for the Homeless (ARCH) and on the Alabama Alliance to End Homelessness (ALAEH). As an ARCH board member, state level coordination of homeless services targeted for individuals in rural areas can be accomplished. ADMH representation on the ALAEH Board assures statewide planning and policies pertaining to homelessness consider the needs of those individuals with serious mental illness. In 2014, HUD's Continuum of Care Homeless Assistance Programs Point-In-Time Counts reflected 4561 individuals and families were identified as homeless statewide with 78.2% in shelters and 22.8% unsheltered. Of this total population, 15.98% were identified as chronically homeless, 22.0% identified as seriously mentally ill, 21.2% as having a chronic substance use condition, 1.8% with HIV/AIDS, 10.4% as victims of domestic violence, and 11.8% as veterans.

ALAEH holds membership from all Continua of Care and the Alabama HUD Field Office affiliates. This agency provides statewide training, networking opportunities, and resource information by providing conferences for which those who serve homeless populations. ALAEH, LICHA, and Collaborative Solutions, Inc. co-sponsor an annual statewide conference targeted towards service providers and individuals with lived experience. Through application, the PATH technical assistance center has partnered on numerous occasions with the Department and with ALAEH to conduct joint trainings at this conference.

Alabama has implemented SOAR training statewide. In 2007, The Department's Office of Policy & Planning partnered with the former Governor's Office of Faith Based and Community Initiatives (GFBCI) to initiate the SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative in Alabama. SOAR has been instrumental in

providing the skills needed for service providers to directly impact homelessness and to move forward in accomplishing the overall arching goal of the States' Plan to End Homelessness, the States' Comprehensive Mental Health Service plan, PATH outcome targets, as well as local plans to end homelessness.

It should be noted that children and adolescents are served, when part of a homeless family, by PATH case managers and by specialized children's case managers in the mental health regions, which have dedicated children's case management. The major provider of homeless services for children and adolescents is the Department of Human Resources (DHR), the child welfare agency. Runaway youth are also identified and referred for other mental health services, including case management, by runaway shelters located across the state. The ADMH staff also participates in the training of the state's law enforcement personnel. Since the police are frequently the first to encounter runaway youth, a considerable amount of time is allocated for discussion of identification and referral for mental health services.

Medical, Dental, and Health Services

For consumers who are Medicaid or Medicare eligible, almost every type of medical care is provided. Very often the only barrier to service is finding providers who serve Medicaid consumers. Other, non-Medicaid eligible clients have typically exhausted health care resources such as insurance, and must rely on health care available in their community on an indigent basis. Typically, local Public Health departments and community health clinics are the main referral resources used by case managers to meet the primary health care needs of their consumers. Local hospitals provide a very limited amount of inpatient care to indigent consumers. Because of historical practices among indigent consumers, many emergency rooms provide the only primary health care some consumers get. Individuals with mental illness have wrestled with the health care issue for years and in general this is one of the few areas where children and adolescents fare better than the adults. For example, Medicaid benefits for persons under 21 can exceed usual limits when indicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Children and adolescents in the care of DHR and DYS receive medical care from these agencies, as well as through school nurses where available. In addition to coverage by Medicaid, dental services are covered by AllKids, Alabama's SCHIP program.

The importance of improving coordination and collaboration with primary medical providers is underscored by the finding that persons with mental illness die on the average 25 years earlier than the general population, due in large part to un- or under-treated primary medical conditions. The Department received a Transformation Transfer Initiative Grant in FY08 and in FY10 to support efforts to improve integration of primary and mental health care. The following partners were convened to assist in planning grant activities: Alabama Medicaid Agency, Department of Public Health, Alabama Hospital Association, Alabama Academy of Family Physicians, Alabama Primary Health Care Association and American Academy of Pediatrics – Alabama Chapter. In FY08 ten regional meetings were conducted to obtain ideas from both primary and mental health providers relative to barriers and opportunities to improve collaboration. The findings from the regional meetings provided the foundation for the efforts funded in FY10. There are three elements to the current grant: 1) expert panels of physicians to discuss their perspectives on collaboration; 2) provide grants to six areas to develop written plans for improving collaboration locally; and 3) support for the Child and Adolescent Psychiatric Institute focusing on primary care collaboration.

Consumers who are in state hospitals are provided medical care as part of their involuntary confinement where there is no insurance or other source of coverage for medical expenses. The state hospitals became

tobacco-free on January 1, 2010. Consumers who have no health insurance and who reside in ADMH community residential programs have minor medical services paid by the provider. There is a limited statewide fund for residents of foster homes to pay for incidental medical expenses when there is no other source of revenue.

Most of the adults with serious mental illness and youth with serious emotional disturbances have Medicaid coverage for medical and dental services. However, it is a challenge to find providers in some areas who will accept Medicaid. Case managers provide a vital service by linking consumers to individual practitioners who will accept Medicaid or who will agree to see consumers on a sliding scale or no fee basis. Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

Access to dental care is often cited as an unmet need for consumers. The University of Alabama in Birmingham School of Dentistry also provides free clinics around the state. The waiting list for these clinics is very long. Case managers assist consumers in getting on the waiting list for any available free clinics. In some areas of the state, local dentists volunteer time for free clinics. Again, the amount of time and the range of services are limited.

In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, the Department has promoted health and wellness education and activities. During the last several years, the annual Consumer Recovery Conference has provided a platform for conducting wellness screenings for a significant sample of consumers in attendance from all over the state. The 2015 Alabama Institute for Recovery had approximately 90 consumers to volunteer for screenings. Screening methods included checking blood pressure for hypertension, body mass index for obesity, and blood glucose for diabetes. Due to restrictions in funding, no lipid tests were conducted to check for high cholesterol. ADMH acknowledges that research suggests smoking prevalence among U.S adults with mental illness or serious psychological distress ranges from 34.3% (phobias or fears) to 88% (schizophrenia). This was the third year in which the Fagerstrom Index was utilized to screen for nicotine dependence. Screenings were provided in partnership with Pfizer. The results of the screenings show a high degree of co-morbidity with diabetes, obesity, and hypertension. Health information and smoking cessation information was disseminated at this event. (see attachment)

RURAL ACCESS

For purposes of classifying catchment areas as rural, the criterion was that the area not include a Standard Metropolitan Statistical Area (SMSA population =/> 50,000) There are 10 community mental health center catchment areas that currently meet this criterion: Baldwin, Cahaba, Cheaha, Cullman, East Central, Mountain Lakes, Northwest, South Central, Southwest, and West Alabama. The table below lists the ten rural mental health regions and the number of adults in the region

who were SMI and children and adolescents in the region who were SED and who were served by the local mental health centers during FY14. A total of 58,163 adults who were SMI were served by the local mental health centers during FY14, and 19,150 or 32.92% were served in the ten rural regions. A total of 25,334 children and adolescents who were SED were served by the local mental health centers during FY14, and 7,687 or 30.34% were served in the ten rural regions. This relationship indicates that adult with serious mental illness and children and adolescents with serious emotional disorders in rural regions continue to have the same access as in previous years. The two most frequently identified areas of need in rural areas are transportation to needed services and child and adolescent psychiatric services. Medicaid coverage of transportation services should assist in maintaining treatment access in rural areas. Services available to children and adolescents in rural areas will be maintained, and efforts will be made during the year to increase services by equal inclusion of rural areas in the implementation of legislation for the "Multi-Need Child". Each county facilitation team receives funds under the Children's First legislation to assist with wrap-around services for children in their county. The amounts of these vary as a function of their 2000 census for children and adolescents under 18 years of age. In regard to "mini grants" awarded to county facilitation teams under the previously funded CASSP Infrastructure Grant, all counties had equal access to grant funds.

Rural Regions	**# of SMI Adults Served FY 14**	**# of SED C&A Served FY 14**
Baldwin County	1,773	1,155
Cahaba	1,491	468
Cheaha	2,436	519
Cullman County	1,256	702
East Central Alabama	1,816	779
Marshall – Jackson	1,708	719
North West Alabama	2,300	1,501
South Central Alabama	2,700	650
Southwest Alabama	2,054	725
West Alabama	1,616	469
Total SMI/SED Rural Served	19,150	7,687
Total SMI/SED Served	58,163	25,334

% Rural of Total SMI/SED Served Statewide	32.92%	30.34%

Medicaid coverage of the centers as providers of Non-Emergency Transportation assists community mental health centers to maintain/expand transportation services, particularly those in rural areas. The chart below shows the number of consumers for whom transportation services have been billed to Medicaid through for FY14.

Medicaid Transportation Units (0ne/Consumer/Day) for FY14

Center	FY14 Consumers	FY14 Units
AltaPointe (Mobile)	741	14,019
Baldwin	38	2,240
CED	212	2,084
Cahaba	351	11,411
Calhoun-Cleburne	313	15,824
Cheaha	132	431
Chilton-Shelby	64	794
Cullman	109	2,373
East Alabama	339	29,525
East Central	166	6,378
Huntsville	255	8,966
Indian Rivers	40	2,126
JBS	499	40,773
North Central	478	23,739
Montgomery	261	7,012
Northwest	707	47,839
Riverbend	582	23,908
South Central	266	17,751

Southwest	149	8,214
Spectracare	254	26,039
West Alabama	39	3,173
Total	5,995	294,579

Through previous partnership with Sprint, and informal arrangements with Sorenson Communications, and ZVRS, the number of videophones in use by deaf people with mental illness through the state had grown substantially. A vast majority of our consumers now have videophones, which are much better suited to their needs than older and increasingly obsolete text-based TTY devices. These connections allow consumers who are deaf and have mental illness more rapid response to their needs and more ready access to therapist than they had previously. The same network also allows Office of Deaf Services (ODS) staff interpreters to more efficiently serve deaf and hearing consumers through remote video interpreting. ODS has a formal contract with Birnbaum Interpreting Service based in Washington, DC> for video Remote Interpreting to cover times and slots when staff or contract interpreters are not available. Another emerging benefit from this network is more ready access to peer support as consumers in recovery in one part of the state can mentor those in another – a tremendous advantage in a low-incident, widely dispersed population. ODS is working to expand its ability to tap into telecom health and psychiatry networks, some of which use equipment that is not cross-compatible.

Increased use of telecommunication technology makes services available in more locations and decreases travel time. Many of the centers are using telecommunication equipment to participate in treatment team meetings at the state hospitals, screen hospital residents for residential placement, and to provide families an opportunity to visit. Initial poor connectivity issues have been addressed with a resulting improvement in quality of interaction. The use of telecommunication equipment has been well-accepted by most clinicians and consumers. The Medicaid Agency, based in part on experience in the mental health system, now covers telepsychiatry under the Physician's Program in addition to the Rehabilitation Option.

OLDER ADULTS/ELDERLY

Community based services are provided to older adults through the existing community mental health center service structure. There were 17,694 individuals aged 55 or older who had received services from a mental health center during FY14 which makes up 18% of the total population served and 25% of the adult population served. The following list shows the duplicated number of recipients aged 55 or older by service type:

Residential	1,777
Day Treatment	1,452
In-home Intervention	211
ACT	374
Case Management	2,616
Outpatient	16,880

Based on these numbers, older adults are receiving a variety of services through community mental health centers. During FY14, adults over 55 years of age make up 34% of the total adult population receiving

Residential services and make up 33% of the total adult population receiving ACT services. Mental health centers provide both direct services to residents of nursing homes as well as case consultation to the operators.

During the second half of FY07, a small pilot project was started to purchase local Assisted Living Facility beds for individuals appropriate for this level of care who were residing in the state-operated Mary Starke Harper Geriatric Hospital. This pilot was successful enough that the pilot was expanded statewide. In FY13, 28 and in FY14 27 individuals have received services through contract Assisted Living Facilities.

In July, 2009, ADMH closed its 30 bed state operated psychiatric nursing facility Alice Kidd. Most of the residents were placed in the community. Those who could not be placed in the community were transferred to another state operated psychiatric facility, Mary Starke Harper Hospital, which serves geriatric patients committed to the Department. Nursing home and Assisted Living Facilities have been used as community resources for the older residents in need of transitioning out of state hospital care. ADMH participated in planning for a Money Follows the Person grant application directed to improving discharge opportunities for residents of nursing homes and Mary Starke Harper Geriatric Hospital. ADMH continues to work closely with the Alabama Medicaid Agency on the implementation of Money Follows the Person.

Evidence-Based Practices

Evidence-based practices utilized in in Alabama are described below:

Assertive Community Treatment (ACT) and the Program for Assertive Community Treatment (PACT)

ACT and PACT have served as a critical element in the diversion of adults considered to be at high risk for readmission to a state psychiatric facility. Alabama began developing ACT and PACT services in 2001. The model used is based upon the principles of PACT as outlined in the SAMHSA Toolkit. However, when the model was adopted, the ADMH EBP Workgroup modified the national model to focus on mental health services using primarily a three member team in addition to a part-time psychiatrist. Mental Illness Program Standards require that the 3 full-time equivalent positions include at least 1 full-time master's level clinician, at least one half time registered nurse or licensed practical nurse, and one fulltime case manager. The remaining half time position could be filled at the agency's discretion by a master's level clinician, a nurse, or a case manager. The Substance Abuse Division (SA) funds SA treatment specialists for 5 of Assertive Community Treatment (ACT) Teams. The role of this specialist is to provide both direct services and expert guidance in how other team members can improve skills in the recognition of and treatment for substance abuse disorders. There are currently 16 certified ACT and 2 certified PACT programs in operation. For the consumer to staff ratio for the modified team is 1:12. The size of the team was based on the minimum necessary to meet the treatment and support needs of consumers while maintaining conformance to the core principles. Given the predominantly rural nature of the State, there are few areas that could support a full fidelity PACT team costing approximately $1 Million per year. The two PACT teams are currently located in our most urban city, Birmingham.

Illness Management and Recovery (IMR)

The University of Alabama Department of Psychiatry and Behavioral Neurobiology submitted the winning proposal to be a Center of Excellence to assist ADMH to implement evidence-based practices for adults with serious mental illness. The Alabama Institute for Mental Health Services (AIMHS) was created and provided training and monitoring for eight pilot sites on implementation of Illness Management and Recovery (IMR). The trainer, Patricia Scheifler, is a national expert. For a variety of reasons, the contract for the Center of Excellence was not renewed in FY10. ADMH did not have the capability to continue the

training and monitoring necessary to assure acceptable fidelity to the model. For that reason, IMR services are not reported.

Permanent Supportive Housing (PSH)

As stated previously, housing continues to remain a critical gap. As a means to offer housing opportunities in a manner most in keeping with the latest evidence for best housing practices and to foster community integration, ADMH dedicated funding to support the development of evidence-based housing projects. In FY08, nine pilot sites were selected to implement Permanent Supportive Housing (PSH) projects creating housing capacity of this type by 108 beds. Additional projects have become operational as a result of the community service expansion efforts of the downsizing and closure projects resulting in a total of 324 Permanent Supportive Housing beds.

Supported Employment: Individual Placement and Supports

Employment opportunities for consumers are not well developed within the mental illness service milieu and are identified as a system weakness. In Alabama, 65,615 adults with mental illness were served by community programs in FY 14. Of those served, only 11% reported being employed either part time or full time. Nearly 19% reported being unemployed but looking for work, and 69.6% reported not being in the labor force due to a disability or other reason. Individuals receiving mental health services who also reported being employed full time dropped from 8,049 in 2007 to 4,578 in 2014 representing a 43% reduction in full time employment.

Alabama Department of Mental Health and the Alabama Department of Rehabilitation Services have forged a longstanding collaboration in serving disabled populations. Concerted efforts of this collaboration have targeted individuals receiving mental health services. In FY14, the Alabama Department of Mental Health (ADMH) was awarded the Substance Abuse Mental Health Services Administration (SAMHSA) *Supported Employment: Transforming Lives* grant. This 5 year grant will provide the opportunity to implement evidence-based supported employment services at two pilot locations AltaPointe Health Systems and Chilton-Shelby Mental Health Center. The program goal is to prioritize and offer full access to employment through Individual Placement and Support services for people who do not benefit from traditional vocational services. Key partners include Dartmouth Psychiatric Research Center, the Auburn Center for Disability Research and Services, and the Alabama Department of Veterans Affairs.

Grant activities will include 1) establishing a Supported Employment Coordinating Committee tasked with overseeing the implementation of IPS programs throughout the state, coordinating cross-agency collaborations, providing guidance to IPS policy development, and creating a financial plan to ensure sustainability; 2) **c**reating a comprehensive IPS Supported Employment Training and Technical Assistance Program using in-person and virtual platforms; 3) implementing high fidelity IPS programs in two pilot communities, providing access to IPS for at least 450 consumers over the 5-year period, providing benefits counseling, using certified peer support specialists to engage underserved populations; and 4) Outreach to Veterans in the State of Alabama to ensure all veterans in need of mental health services who prefer to seek treatment at local community mental health centers have the opportunity to participate in IPS service from an Alabama community mental health provider.

Prior to the award of the SAMHSA Supported Employment grant described above, , little has been done in the way enhancing employment opportunities for individuals with serious mental illness outside of limited funds dedicated for the employment of certified peer specialists (CPS) within the provider network. Traditionally community mental health programs focus on job readiness training and referrals

to Vocational Rehabilitative Services. Due to the lack of a dedicated funding source, the means for offering evidence-based Supported Employment services as a vehicle to obtain competitive employment within the community at large remains undeveloped.

ADMH has been able to establish framework from which to foster employment based services. In FY11, ADMH received an Employment Development Initiative (EDI) grant which initiated preliminary supported employment planning activities. EDI funds supported Train the Trainer technical assistance for the end purpose of creating the capacity to conduct its in-state Certified Peer Support Specialist Training. Sponsored by EDI grant funds, experts on the **Individual Placement and Support (IPS) supported employment evidence-based** model served as keynote speakers at the EDI grant sponsored Alabama's Supported Employment kick-off event in 2011. These initial activities have uniquely positioned MI Community Programs to foster a relationship with Dartmouth IPS Supported Employment Center. Dartmouth continues to provide guidance to Alabama through the IPS Learning Community and as the technical assistance provider for the SAMHSA Supported Employment grant previously described. Within the Department of Mental Health, the Division of Mental Health and Substance Abuse works closely with the Developmental Disabilities Division, where is housed an employment specialist who works exclusively towards the development and expansion of competitive employment programs for the Intellectually Disabled population. Through cross Division collaboration, staff within MI Community Programs has invitation to participate in some of the ID supported employment planning and development activities and initiatives. These activities include participation in the DD Supported Employment Workgroup, Alabama Association of Persons for Supporting Employment First conferences, Employment First State Leadership Mentoring Program community of practice, and Supported Employment Leadership Network (SELN) opportunities.

In an effort to affect state policy, ADMH collaborated with other state agencies in an effort to pass an Employment First Bill. First introduced in the 2013 legislative session, the bill was well received but ended before the bill was adopted. Legislation was reintroduced in the 2014 legislative session, but failed to reach the floor for vote. Plans are underway to again introduce Employment First legislation in 2015 session. The Employment First Bill will affix "employment" as a legislatively affirmed priority. The passing of this bill will be viewed as a turning point in shaping state driven policy and funding mechanisms necessary to spark a transmutation in traditional services systems.

Consumer Operated Services

Consumer driven recovery, such as consumer run drop-in centers and support groups are seen as essential elements of the continuum of care, but these services are not covered in the Department's contract with community mental health centers. The Block Grant is used to support the development of consumer-operated services as well as the annual consumer conference. There are five operational drop-in centers serving on average an approximate total of 114 consumers on any given day. Within the state, there are twenty-four support groups, 4 statewide consumer organizations, and 10 NAMI connection groups.

Certified Peer Specialists

ADMH has long valued the power of peers to support fellow consumers and promote recovery. ADMH first established the position of peer support specialist in 1994 at Greil Hospital and later expanded the program to all state facilities. In 2008 provisions were made to expand peer support services to the community provider network. Funding cuts restricted full expansion of peer services to every provider agency; however, due to the 2011 efforts of shifting hospital funds to community services, peer support

services has once more found an opportunity to flourish. Not only has the movement towards peer services lead to the credentialing requirements for the certification of peer specialists, but it has evolved in the creation of specialty peer specialists training such as peer bridger services and peer specialists funded to assist in promoting health and wellness for consumers with chronic physical illnesses in addition to serious and persistent mental illness. Efforts continue in pursuit of Medicaid funding for this service reflective of it's true worth. Currently there are 54 certified peer specialists/peer Bridgers employed at community mental health centers, one located at a state hospital, 18 others serving in mental health related positions, and 10 employed by mental health consumer and family organizations.

ADMH is working to expand opportunities for Certified Peer Specialists, especially with Youth Certified Peer Specialists. Jefferson, Blount, St. Clair Mental Health Authority (JBS), Hill Crest Hospital in Birmingham and ADMH are piloting a project providing peer support for adolescent girls in a C&A psychiatric residential treatment facility. JBS has also established an Urgent Care Center incorporating the use of Certified Peer Specialists.

ADMH along with Chilton Shelby Mental Health in Calera and AltaPointe in Mobile is piloting a project creating supported employment teams. Each team will include Certified Peer Specialists.

Several previously employed specialists used their knowledge, experience, and skill gained from CPS training and employment to enhance their prospects and obtain higher paying positions outside of the mental health realm or to return to college.

Evidence Based Practice	Estimated Number Served in FY14
Assertive Community Treatment	1,055
Family Psychoeducation	0
Integrated Treatment for Co-occurring Disorders (MH/SA)*	0
Illness Management and Recovery	0
Medication Management	0
Permanent Supportive Housing	311
Supported Employment	0
Peer Support Services**	116

*There are four programs that identify themselves as specifically treating individuals with co-occurring disorders. Mental health centers address the co-occurring treatment needs of consumers through parallel and sequential mental illness and substance abuse services, but largely not in programs that would meet fidelity measures for co-occurring treatment.

**Although ADMH created reportable activity codes to capture the services provided by CPS/Peer Bridger's, the number reported does not accurately reflect the actual number served and is only representative of peer activities at two mental health organizations. Eighteen community mental health centers are providing peer support services. At present, there is no incentive to report individual episodes

of peer services since no reimbursement mechanism exists. The Office of Consumer and Ex-patient Relations estimates numbers served at a much higher rate than those reported in the grid above.

C&A EBPS

In regard to children and adolescents, a number of evidence-based practices (EBP) have been under consideration in Alabama. The Core Performance Indicators include Therapeutic Foster Care as the one of the required EBP for Uniform Reporting System requirements. In Alabama, Therapeutic Foster Care is funded and licensed by child welfare, the Department of Human Resources (DHR). Because the Department of Mental Health cannot regulate or monitor these services, there are no goals listed below related to it. It is important to note that DHR has contracted with a Multi-Systemic Therapy (MST) provider in several areas in Alabama and DYS has contracted with a MST provider in one region. Funding services that have been demonstrated to be effective were considered by ADMH. In FY06 and FY07, the C&A EBP Workgroup worked toward formal recommendations regarding the selection and implementation of appropriate evidence-based practices. In FY07, the EBP workgroup recommended the following: Cognitive Behavior Therapy (CBT) in the form of developed models be considered for implementation. One such CBT model recommended by the workgroup was Coping Power. The EBP workgroup also recommended securing outside assistance in any implementation of a child and adolescent focused EBP and that a Center of Excellence be considered for the request for proposal process similar to the course of action currently being incorporated by ADMH with the adult SAMHSA Toolkits (this Center of Excellence no longer exists). The EBP workgroup further recommended that C&A In-Home Intervention be evaluated/assessed by a Center of Excellence as to work toward this service being recognized as a "best practice". These recommendations were submitted to the Mental Illness Coordinating Sub-Committee. In FY08 and FY09, the EBP workgroup focused on the "A Guide for Selecting and Adopting Evidence-Based Practices for Children and Adolescents with Disruptive Behavior Disorders" Guidelines issued by SAMHSA to assist in making further recommendations on C&A EBP's. During the same timelines, ADMH was working with NASMHPD on the C&A EBP reporting issues and a National movement to have additional New Optional Table to URS for Reporting Child and Youth EBP's. The first priority of focus for the C&A EBP workgroup and the National workgroup that ADMH was involved was reviewing the EBP's from the SAMHSA's Guide which have a specific focus on treatment (versus prevention) and have demonstrated a good level of evidence. From those reviewed, the C&A EBP workgroup identified both prevention and intervention programs to be recommended. These were a smaller list than those being recommended by the NASMHPD workgroup. Because the EBP's in the SAMHSA's Guide primarily focused on disruptive behavior disorders, the C&A EBP Workgroup and the NASMHPD Workgroup researched other EBP's for consideration. The C&A EBP Workgroup identified the other EBP's for recommendation which mirror the recommendations of the NASMHPD Workgroup. The C&A EBP Workgroup encountered more difficulty around developing implementation strategies for recommended EBP's. With C&A EBP's, they are created and owned by an entity, usually a University. So, implementation is based on ability to work with the defined EBP entity. This has to be done with each EBP. For future implementation, the C&A Workgroup recommended to the MI Associate Commissioner the following, as funding permits:

1. Develop a ADMH approved C&A EBP menu that would allow community providers to determine which EBP best works in their community as to best move toward transformation.
2. Contact each EBP entity approved and determine all necessary steps for implementation to include, but not limited to, training, ownership of data, certification, and all costs.
3. Consider a Center of Excellence concept similar to what has been implemented with Adult EBP's.

To properly implement C&A EBP's, a Center of Excellence concept is what has been utilized in other states to effectively and efficiently implement EBP's due to complex training demands, certification demands, and data/outcome demands.

4. Consider exploring avenues to have C&A In-Home Intervention evaluated/assessed as a service that could be recognized as a "promising practice" or "best practice". To do this would only be accomplished by either working with a Center of Excellence or University.
5. As funding is the driving force for Implementation, next steps for implementation are even more complicated. Monies would have to be secured to do so either within the ADMH budget, with collaborations with other State Agencies, and/or through grant opportunities.

In FY10, efforts continued to identify and develop opportunities to implement the recommended EBPs. In FY08, ADMH partnered with the University of Alabama (UA) and Dr. John Lochman, creator of Coping Power to apply for a research grant. Dr. Lochman is the Director of the Center for the Prevention of Youth Behavioral Problems on the UA campus. Coping Power is an EBP recognized by SAMHSA. Dr. Lochman applied for a research grant that would partner with community mental health centers in the use of Coping Power. This would be in partnership with UA, ADMH and community mental health centers. The grant was submitted in July 2008 but was not awarded. Collaboration continues to work toward securing funding to demonstrate this EBP. ADMH also participated with the UA in the application of a NIH research grant. This grant opportunity would allow for the gathering of baseline data from mental health providers over a two year period of time as to assess C&A In-Home Intervention (IHI) services. This baseline data would be utilized as a platform to move toward IHI being recognized as a "promising practice". The UA, in collaboration with ADMH, applied for this grant in June 2010 but it was not awarded. In October 2010, ADMH received notification that the SAMHSA Child Mental Health Initiative Grant (SOC) application was awarded. This grant application represented a unique opportunity to develop a system of care that would serve children with serious emotional disturbance and their families in a three county rural community. ADMH contracted with a community mental health center for the implementation with ADMH working closely with this system of care process. After year three of the SOC grant, ECCHO met sustainability. Several EBPs were being considered for implementation within this System of Care (SOC) Grant to include: Wraparound, Coping Power, Dialectic Behavioral Therapy (DBT), Positive Behavior Support (PBIS), Bright Futures, Assuring Better Child Development (ABCD), and Cognitive Behavior Therapy and Motivational Enhancement Therapy (CBT-MET).Only Coping Power had been initiated for implementation. Meetings have occurred on how to capture the data within the ADMH data system once Coping Power is fully implemented through ECCHCO. In August of 2013, Dr. Lochman at UA applied for a three-year Patient-Centered Outcome Research Institute grant that would partner with ADMH and community mental health centers to train up to 120 mental health clinicians to implement Coping Power and establish Coping Power programs at multiple sites across the state. However, we were not awarded to grant application.

Evidence Based Practice	# Served FY14 Actual	# Served FY15 Actual	# Served FY16 Target
Multi-systemic Therapy	0	0	0
Functional Family Therapy	0	0	0

Therapeutic Foster Care	0	0	0

SAMHSA Child Mental Health Initiative/System of Care (SOC) Grant (The ECCHCO Project) was awarded to ADMH in October 2010. This grant application represented a unique opportunity to develop a system of care that would serve children with serious emotional disturbance and their families in a three county rural community. ADMH contracted with a community mental health center for the implementation with ADMH working closely with this system of care process. This project addressed the comprehensive needs of child and adolescents with SED and their families by implementing a system based on the core values: community based with outreach services, family-driven, youth-guided, culturally and linguistically competent, and individualized treatment planning. The ECCHCO Project utilized the voices of families and youth at all levels to include policy and decision making. There were full-time employees as the Lead Family Contact and the Youth Engagement Specialist. Both were members of the state level children's advisory committee, the MI Child and Adolescent Task Force, as well as the Youth Engagement Specialist being a member of the MI Planning Council. At the end of year three of the grant, the progress of sustainment and financial considerations allowed the ECCHCO Project to become independently sustained apart from SAMHSA funding. ECCHCO continues to sustain improvements in children's physical, social and emotional health services in Pike, Bullock and Macon Counties established during its existence as a federally funded System of Care grant program. Strong community partnerships linking parents, youth, education, local government and healthcare agencies continue to be cultivated and utilized to improve the lives of children and their families in this part of rural Alabama. There continues to be a ECCHCO Advisory Council that is utilized as the steering committee for continued efforts. There continues to be a full-time Lead Family Contact and there continues to be a voting membership for both a family and youth representative from ECCHCO on the state level children's advisory committee, the MI Child and Adolescent Task Force, as well as a voting youth membership from ECCHO on the MI Planning Council. It is the intention to utilize this SOC site as a "laboratory of learning" as to transcend traditional mental health boundaries by integrating social services, education, juvenile justice, and primary care resources with mental health services.

Child and Adolescent Needs and Strengths (CANS)

Efforts to move toward the use of a state-wide Functional Assessment Tool became a focus of attention of the Child and Adolescent Task Force for several reasons. The use of a functional assessment tool could serve as a uniformed state-wide reporting process that would be a valuable approach for consistently capturing measurable data elements that are comparable. The use of a functional assessment tool would serve as an instrument to drive treatment planning that is individualized, family-centered, and strength-based. The use of a functional assessment tool would provide an avenue to capture data needed to assist with mandatory reporting elements. The use of a functional assessment tool would provide rich data that would enhance grant applications which is highly valuable considering the current state and federal economic conditions. Recommendations were made to the Associate Commissioner to move in this direction and, on October 1, 2010, the Child and Adolescent Needs and Strength (CANS) Functional Assessment Tool was implemented state-wide. The CANS is being used statewide for children and adolescents receiving services through the public mental health system. This transformation tool, consistent with system of care values and principles, focuses on the needs of the children and families. The CANS-Comprehensive provides a common language, objective criteria to support decisions about

intervention plans and intensity of services, monitors progress through outcome measures, and supports quality improvement initiatives. Information from the CANS-Comprehensive will support decisions at multiple levels – direct services, supervision, program management, and system management. For community mental health providers, the *CANS for Alabama Comprehensive Multisystem Assessment (5 to Adulthood) or the EC-CANS for Alabama Comprehensive Multisystem Assessment (0 to 4 Years)* tools is being utilized. The CANS was developed by John Lyons, PhD, in collaboration with several states' child serving systems and Dr. Lyons worked directly with the Department on this venture. Dr. Lyons completed the "Super User" training/certification process in June 2010. Approximately 107 CANS Super Users were trained to support local implementation of the CANS-Comprehensive training, supervision, and integration into everyday practice. Alabama's mental health public system providers were trained and certified as "Certified CANS Users". A database, the Alabama Behavioral Health Assessment System (ABHAS), was developed to capture the CANS data and to provide a variety of reports to users at all levels of the child-serving system. ADMH Data Management Division created a web-based application in collaboration with Dr. Lyons to interface with this database, and the ABHAS website was initiated on October 1, 2010. All MI contracted providers have C&A staff trained and a CANS completed on all C&A consumers as of April 1, 2011. In 2013/2014, ADMH moved into an enhancement process for the CANS certification/re-certification process and joined a national consortium to achieve this, The Praed Foundation. By January 2015, all the mental health providers contacted with ADMH were members of the Praed Foundation under the jurisdiction of Alabama. This allowed ADMH to enhance the timeliness of certification/re-certification and the technical guidance that enriches to process of utilizing the CANS as a multi-purpose tool.

School-Based Mental Health (SBMH) Collaboration

ADMH appreciates a long-standing collaboration with the Alabama State Department of Education (ALSDE) stemming back to 1999. ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred school systems in the state. For numerous years, case managers, in-home intervention teams, and outpatient clinicians employed by the Community Mental Health Centers (CMHCs) have had frequent contact with the educational system on behalf of children with a serious emotional disturbance and their families. Since 1999, the two agencies have collaborated to blend funds and resources on projects that began with day treatment programs and now extended into an integrated, school based project, School-Based Mental Health (SBMH) Collaboration.

From FY 12 and FY 15 to date, sixteen of the 22 community mental health centers (CMHCs) of Alabama and over 60 Local Education Authorities (LEAs) have conducted initial orientation meetings describing the SBMH collaborative process. Of these, 12 CMHCs and 36 School Systems have entered into formalized agreements as SBMH Collaboration Partners. The SBMH model improves access to appropriate mental health services by children who need them by placing a Master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. ADMH and ALSDE continue to jointly promote the School Based Mental Health Collaboration across the state, and have presented workshops on SMBH at ALSDE's MEGA Conference and Transition Conference in FY 12 and every year thereafter through FY15. SBMH Partner CMHCs and School Systems are currently gathering information to establish School Year 2014-2015 as the "baseline year for SBMH Data. This information will be used to analyze the effectiveness of SBMH over subsequent years.

ADMH feels that by implementing this promising practice, a system can be developed that ensures a more preventive effort to integrate a seamless system of mental health care in educational settings. All of this is in an effort to provide treatment that is more holistic and in a way to build strength and resiliency for young people personally and with their educational successes.

First Episode Psychosis (FEP)

ADMH is also in the process of implementation of First Episode Psychosis (FEP) which requires certain training elements in order to meet the fidelity of the model. For specific information regarding collaborative efforts with FEP, please see Section IV, Environmental Factors and Plan: 5. Evidence-Base Practices for Early Intervention (5 percent set-aside).

Substance Abuse/Co-Occurring Disorders

A major gap in the current system of care for adults and children and adolescents is coordinated care for individuals with co-occurring mental illness and substance abuse problems. Often programs and services are not available due to eligibility rule-outs in their admission criteria, or complex funding requirements may hinder access to coordinated substance abuse and mental health services. As previously discussed, ADMH Administration is dedicated to making positive strides in this area and first steps were taken by combining the Mental Illness and Substance Abuse Divisions. At present within the Mental Health Substance Abuse Services Division, the executive staff works directly and in coordination with each other. There are several Offices within the Division that address MI/SA/COD such as the Office of Certification, the Office of Deaf Services, and the Office of Performance Improvement. Within all other offices, coordination of care is direct and bi-directional, to include adult and children/adolescents.

One of the major responsibilities of the Office of Children Services was the planning and development of programs and services across the Department's three divisions: Mental Illness (MI), Developmental Disabilities (DD), and Substance Abuse (SA). The funding, in FY01 and FY02, of a Juvenile Court Liaison for each community mental health center catchment area is an example of an initial effort to improve the service capacity and flexibility in addressing co-occurring disorders. Since the juvenile court is frequently where children and adolescent with co-occurring disorders first enter the system, the Juvenile Court Liaison will assist the court in assessing the individual and make appropriate treatment recommendations. They will also be responsible for linking the youth and their family members to needed services, to include substance abuse services. With changes in the administration in FY12, the Office of Children Services was terminated and the services within that office were distributed to the two service divisions (MHSA and DD). But the integrity of the programs that served co-occurring issues remained intact with processes being developed to maintain their integrity to include the Juvenile Court Liaisons.

Within the Mental Health Substance Abuse Services Division, the decision was made that Co-occurring programs would fall under the ADMH SA Program Standards. Dr. Barbara Jackson has been the Co-occurring Disorder's Coordinator and her work focused on the monitoring, coordination, and expansion of Co-occurring programs. Dr. Jackson is currently the Acting Director of Taylor Hardin Secured Medical Hospital so the position as the Co-occurring Disorder's Coordinator is currently vacant.

For FY13-14, there were not any specific co-occurring initiatives nor are there any taking place this current year. In March 2014, the new substance abuse treatment regulations became fully effective. With this change, all treatment programs are under the certification of ADMH SA Program Standards are now

required to be co-occurring capable, as according to the ASAM Criteria. This also makes available rules for programs to obtain a higher level of certification and designation as co-occurring enhanced. The ADMH MHSA Certification team is now surveying programs for compliance with the new rules. In addition, there was one course offered at the Alabama School of Alcohol and Other Drug Studies (ASADS) in 2015 related to co-occurring disorders: Dual Diagnosis: Substance Abuse and Eating Disorders.

Office of Planning and Resource Development (PRD)

Within ADMH, the Office of Planning and Resource Development works with consumers, families, providers, and community stakeholders. PRD strives to educate, inform, and empower regarding issues affecting intellectual disabilities, mental illness, and substance use disorders. PRD works closely with the two service divisions on joint initiatives. Below are efforts of collaboration worth highlighting.

ADPH Emergency Preparedness Collaboration

ADMH has standing membership on the Governor's Office on Disabilities and the Alabama Department of Public Health's Functional and Access Needs in Disaster (FAND) Task Force. Annually, the Department of Public Health (DPH) jointly sponsors a statewide emergency preparedness conference with CDC funds. The last conference was devoted to PTSD and featured the SAMHSA Disaster Distress Helpline. (See attachment). PRD Staff also routinely participate in Alabama Department of Public Health Medical Needs Shelter and Alabama Department of Human Resources Mass Care Shelter planning. ADMH additionally participates in the Governor's Mass Sheltering Task Force and avails itself of training and partnering opportunities available through the AL Emergency Management Agency.

BP Oil Spill Disaster Crisis Counseling Response

In collaboration with SAMHSA and neighboring states, a 32 member crisis counseling team was established to serve residents of Baldwin and Mobile counties through a BP financial award. ADMH was active in this response from June 2010 -December 2014. A targeted program serving school children continued through the summer of 2015. Over 580,000 crisis counseling contacts were made in both counties to include individual, group, educational and outreach services.

Alabama Executive Network for Service Members, Veterans and Their Families (AlaVetNet)

ADMH is the recipient of a SAMHSA Service Members, Veterans and Their Families Technical Assistance award, which served as the nucleus for the development of the Alabama Executive Network for Service Members, Veterans and their Families (AlaVetNet). In December 2013, Governor Bentley established AlaVetNet through Executive Order 42. (See attachment). ADMH Co-Chairs AlaVetNet along with the AL Department of Veterans Affairs. Seventeen (17) other state agencies hold membership in the Executive Network. The goals of AlaVetNet were set forth in a plan, which was submitted to Governor Bentley in 2014 detailing efforts to be accomplished through the following six (6) committees: Behavioral Health, Education, Employment, Family Services, Homelessness, and Legal. (See attachment). AlaVetNet committee membership is open to all interested.

SSI/SSDI Outreach, Access and Recovery (SOAR) Training

The Office of Planning and Resource Development coordinates the provision of SSI/SSDI Outreach, Access and Recovery (SOAR) In-person training throughout the state through a SAMHSA technical assistance

award. SOAR training is designed to facilitate the acquisition of Social Security Administration (SSA) benefits to individuals with a diagnosis of serious and persistent mental illness (SMI) and/or a co-occurring disorder of SMI and substance use. Training is geared to assist individuals who are homeless, at-risk of homelessness or living in doubled up living arrangements. The HUD Balance of State Continuum of Care, the Alabama Rural Coalition for the Homeless (ARCH), is the 2015 recipient of a SOAR award to serve 42 rural areas of Alabama through online training. ADMH partners with ARCH to expand SOAR methodology throughout the state.

Alabama Department of Public Health Collaboration

ADMH networks with the Alabama Department of Public Health (ADPH) through regularly scheduled meetings with its Office of Rural and Primary Health Care. The focus of this partnership is to explore and leverage resources to expand behavioral health services and to recruit and retain treatment professionals.

Section II: Planning Steps – Step 2: Identify the unmet service needs and critical gaps within the current systems

Historically, services have been designed and implemented through a participatory planning process that includes the Mental Illness Planning Council and the Mental Illness Coordinating Subcommittee of the Management Steering Committee. Family members, consumers, advocacy organizations, other state agencies, and providers are represented on these planning bodies. A regional planning process initiated in FY08 added participants into the planning process, primarily consumer and family advocates, to address critical overages in state hospitals and system transformation.

The regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. There have been numerous participants in the regional planning process including consumers, family members, judges, public community providers, state hospitals, and local private providers. The local and regional planning process provided the foundation for ADMH's annual budget request. In FY09, the planning process was expanded to include a separate planning function for children and adolescents. This decision was based on feedback from the previous years of planning and was implemented to improve the voice of children and adolescents and their families throughout the planning process. A series of over 90 adult/children and adolescent local stakeholder planning meetings occurred in late summer and fall 2009. This provided local and regional input in determining unmet needs and critical gaps within the system at the community level. The feedback from this process was utilized within the departmental planning process as a mechanism to introduce local community input and was instrumental in the identification of needs and gaps in service. During FY 2011, ADMH leadership worked jointly with the Mental Illness Coordinating Subcommittee and Management Steering Committee to make recommendations for goal and strategy improvements. This collaboration has resulted in thorough examination of planning targets that reflect the approval of stakeholder partners while balancing the realities of ADMH fiscal parameters and magnifying the benefits of the integration efforts made within the division. This process has continued through FY 2015.

Planning for children and adolescent services is performed as a part of the overall Management Steering Committee process described above via a Child and Adolescent Services Task Force. The Task Force is constituted from a representative group of stakeholders, including advocates and family members whose

primary focus is children and adolescents. This body assesses the needs of the state, designs the conceptual framework, and prioritizes strategic growth of child and adolescent services for the ADMH Mental Illness Division.

A combination of sources was used to identify critical service gaps. For years, ADMH has monitored the utilization of public mental health services through analyzing service data reported to ADMH. This data, in conjunction with periodic survey of the providers, allowed ADMH to identify trends in service utilization by the consumers.

Other sources of data utilized by ADMH include the U.S. Bureau of Census, the National Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Surveys, ADMH web-based housing inventory (MICRS), ADMH certification results from provider site visits, HUD Point in Time count, Housing Needs Assessments, and hospital and community Performance Improvement data sets.

Another very valuable measure ADMH has for identification of gaps in the service delivery continuum for children and adolescents is through its participation in the Case Review Committee of the Multiple Need Child Office. This staffing occurs monthly with legislatively mandated child-serving agencies charged with developing plans for children who have multiple needs and who are at risk of placement in a more restrictive setting.

ADMH has exchanged service data with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, ALL Kids, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements, or informal relationships. Also, ADMH worked with the Administrative Office of the Courts to match the ADMH mental health database with mental health court participants.

PREVALENCE

Community Programs

FY14

Overall Total Served (MI – Community and State Hospital) – 94,478
Overall Total Served (MI Community) – 93,896
SMI Adult (Contract Eligible) – 62,342
SED (Contract Eligible) – 25,775

The 2013 Uniform Reporting System (URS) Table 1 estimate of adults with serious mental illness (SMI) in Alabama is 200,170 and the estimate of children and adolescents with serious emotional disturbances (SED) is 73,848 people which is the upper limit of Level of Functioning equal to or less than 60.

The ADMH definition of Serious Mental Illness is more restrictive than the federal definition in that the diagnostic categories are limited. The types of functional disability are similar between the state and federal definitions. The Alabama public sector's priority population is the SMI population that requires

treatment and care outside the private sector. Many children and adolescents with serious emotional disturbance are served in the private sector, by the Department of Human Resources, by the Department of Youth Services, and by educational agencies. 30.3% of the total C&A served in Alabama compared to 28.9% nationally. 69.6% of total adults served in Alabama compared to 71.0% nationally. The FY14 Uniform Reporting System State Report shows Alabama with a penetration rate of 19.55 per 1,000 population compared to the national rate of 22.78. The community utilization rate is 19.43 per 1,000 population compared to 23.33 nationally. The penetration rate for adults with serious mental illness and children/adolescents with serious emotional disturbance exceeds the national rate in all age categories as follows:

00-17 years	Alabama 22.8 – National 19.0
18-20 years	Alabama 14.3 – National 14.9
21-64 years	Alabama 18.1 – National 16.5
65(+) years	Alabama 6.4 – National 4.2

The following is a description of those individuals who are contract eligible:

DEFINITION OF SERIOUS MENTAL ILLNESS/ DESCRIPTION OF CONTRACT ELIGIBLE CLIENTS (ADULTS)

A: Persons who meet the diagnosis and disability criteria for serious mental illness listed below in Section 1 or who meet the criteria for high risk listed below in Section 2.

Section 1: **Persons who are Seriously Mentally Ill:**

Diagnosis: Any diagnosis listed below in combination with at least two criteria from the disability category:

Schizophrenia and Other Psychotic Disorders

295.xx	*Schizophrenia.*
.30	*Paranoid Type*
.10	*Disorganized Type*
.20	*Catatonic Type*
.90	*Undifferentiated Type*
.50	*Residual Type*
295.40	*Schizophreniform Disorder*

295.70 *Schizoaffective Disorder*

297.1 *Delusional Disorder*

298.8 *Brief Psychotic Disorder*

297.3 *Shared Psychotic Disorder*

298.9 *Psychotic Disorder NOS*

Mood Disorders (Major)

296.xx *Major Depressive Disorder*

.2x *Single Episode*

.3x *Recurrent*

296.xx *Bipolar I Disorder*

.0x *Single Manic Episode*

.40 *Most Recent Episode Hypomanic*

.4x *Most Recent Episode Manic*

.6x *Most Recent Episode Mixed*

.5x *Most Recent Episode Depressed*

.7 *Most Recent Episode Unspecified*

296.89 *Bipolar II Disorder*

296.80 *Bipolar Disorder NOS*

Anxiety Disorders (Severe)

300.01 *Panic Disorder Without Agoraphobia*

300.21 *Panic Disorder With Agoraphobia*

300.22 *Agoraphobia Without History of Panic Disorder*

300.3 *Obsessive-Compulsive Disorder*

Disability: (must meet at least two criteria listed below as a result of one of the above diagnoses)

1. Is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

2. Shows severe inability to establish or maintain personal social support systems.

3. Shows deficits in basic living skills.

4. Exhibits inappropriate social behavior.

<u>Section 2</u>: High Risk (must meet one of the criteria listed below):

l. A person who has a history of ADMH supported inpatient or public residential treatment as a result of an Axis I mental illness diagnosis (excludes mental retardation and substance abuse)

2, A person who without outpatient intervention would become at imminent risk of needing inpatient hospitalization.

B. An individual regardless of diagnosis shall be eligible for one intake per year and pre-hospital screening and crisis intervention as needed.

The following definition was revised and approved in August 1996, by the ADMH Children and Adolescent Taskforce. The revised definition became effective October 1, 1996.

DEFINITION OF SERIOUS EMOTIONAL DISTURBANCE/ DESCRIPTION OF CONTRACT ELIGIBLE CLIENTS (CHILDREN AND ADOLESCENTS)

For the purposes of this agreement/definition a child or adolescent is an individual, age 17 years or less, and a legal resident of the state of Alabama. To be eligible for contract services he/she *must* meet the following criteria for (I & II) *or* (I & III):

I. Diagnosis

Must have a DSM Axis I diagnosis. A primary diagnosis of a "V" code, substance use, or mental retardation does *not* meet criteria.

However, for the purposes of Medicaid Rehabilitation and Optional Targeted Case Management match payments, individuals do not have to meet the criteria listed above, but must, of course, meet Medicaid requirements.

By policy, responsibilities for persons who are diagnosed with Autism and who have dual mental illness and mental retardation diagnoses fall under the jurisdiction of the Division of Mental Retardation within the ADMH.

II. Separated from Family (Out-of-Home Placement)

Separated from family due to a child or an adolescent's admission to, residing in, or returning from an out-of-home placement in a psychiatric hospital, a residential treatment program, therapeutic foster care home, or group treatment program as the result of a serious emotional disturbance.

III. Functional Impairments/Symptoms/Risk of Separation

Functional impairment is defined as a behavior or condition that substantially interferes with or limits a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent or continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

Must have A *or* B *or* C as the result of a serious emotional disturbance:

A. Functional Impairment

Must be of one-year duration or substantial risk of over one year duration.

Must have substantial impairment in *two* of the following capacities to function (corresponding to expected developmental level):

1. Autonomous Functioning: Performance of the age appropriate activities of daily living, e.g., personal hygiene, grooming, mobility;

2. Functioning in the Community - e.g., relationships with neighbors, involvement in recreational activities;

3. Functioning in the Family or Family Equivalent - e.g., relationships with parents/parent surrogates, siblings, relatives;

4. Functioning in School/Work - e.g., relationships with peers/teachers/co-workers, adequate completion of school work.

B. Symptoms

Must have one of the following:

1. Features Associated with Psychotic Disorders

2. Suicidal or Homicidal Gesture or Ideation

C. Risk of Separation

Without treatment there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

Services should be provided in a manner that is accessible to persons of both genders, all ages, and all races/ethnicities. The chart below shows that services are delivered to individuals in all categories.

Measure	FY11	FY12	FY13	FY14	FY15	FY16
	Actual	Actual	Actual	Actual	YTD	Goal
Age:						
0-17	26,980	27,178	27,572	28,531	22,661	25,000
18-20	5,184	4,998	4,663	4,426	3,630	4,000
21-64	64,695	64,177	61,688	59,986	48,886	58,000
65+	5,470	5,667	5,697	5,696	4,848	5,000
Unknown	038	015	179	25	45	
Gender:						
Female	55,141	55,056	53,396	52,438	42,447	50,000
Male	47,208	46,973	46,399	46,181	37,540	45,000
Unknown	026	06	04	46	83	
Race/Ethnicity:						
Am Ind/Al Native	394	347	308	318	234	300
Asian	140	165	177	188	138	150
Black/Afn Amn	36,703	37,410	36,597	35,633	30,814	35,000
Native Hawaiian	34	32	30	32	22	30
White	59,187	60,435	59,040	58,708	45,874	58,000
Multi-racial	1,120	1,136	1,202	1,211	832	1,000
Unknown	4,797	2,612	2,445	2,575	2,095	
Hispanic Origin:						
Hispanic/Latino	1,385	1,516	1,657	1,803	2,323	2,000
Not Hispanic	100,893	100,588	98,128	96,822	77,717	95,000
Unknown	097	033	14	40	30	

Specific to child and adolescent services, ensuring adequate staffing levels are vital. Surveys are conducted to ascertain the number of staff within community programs that provide services for the population with a Serious Emotional Disturbance. Below are the results from those surveys, which reflect a slight increase of the number of FTE positions serving children and adolescents.

Provider	**Total FTE's C/A Staff**	**Total FTE's C/A Staff**	**Total FTE's C/A Staff**	**Percent Change**	**Percent Change**	**Percent Change**
	August 2012	**August 2013**	**August 2015**	**Aug 11-Aug 12**	**Aug 12-Aug 13**	**Aug 13-Aug 15**
Baldwin County	36.5	38	0. Merged with AltaPointe	4.29	4.11	0
AltaPointe	141	162	238.25	6.54	14.89	47.07
Brewer-Porch	148	155	181.63	-13.95	4.73	17.18
Calhoun-Cleb.	18	18	13.5	12.50	0.00	-25.00
Cahaba	9.25	9.25	10.12	-7.50	0.00	9.41
CED	8.5	10.73	9.0	-23.42	26.24	-16.12
Cheaha	9	10	8.2	-18.18	11.11	-18.00
Chilton-Shelby	10.5	10.5	12.50	0.00	0.00	19.05
Cullman	11.25	11.25	13	-2.17	0.00	15.56
East Alabama	29	33	36	-12.12	13.79	9.09
East Central	18	17	17.70	-28.00	-5.56	4.12
Eastside	5	5	5	0.00	0.00	0.00
Glenwood	34	35	38	9.68	2.94	8.57
H'ville-Madison	37.25	42	45.83	2.70	12.75	9.12
Indian Rivers	12.75	12.75	15.5	-25.00	0.00	21.57
J-B-S	65	67	63	-13.33	3.08	-5.97
Marshall-Jackson	15.5	14.5	14.5	0.00	-6.45	0.00
Montgomery	17.2	19.5	18.3	-26.81	13.37	-6.15
North Central	31	29.5	35.5	16.98	-4.84	20.34

Northwest	81	81.5	84	0.00	0.62	3.07
Riverbend	44.25	39	34.5	-5.85	-11.86	-11.54
South Central	12	17	13	0.00	41.67	-23.53
Southwest	17	15.4	15.79	0.00	-9.41	2.53
UAB	10.5	10.5	10.5	0.00	0.00	0.00
West Alabama	6.5	5.5	5.5	8.33	-15.38	0.00
Western	3	3	3.8	-7.69	0.00	26.67
Wiregrass	8.46	8.48	17	-23.09	0.24	100.47
TOTALS	**839.41**	**880.36**	**959.62**	**-5.15**	**4.88**	**9.00**

An analysis of the unmet service needs and critical gaps within the current system

Self-Directed System of Care

Individuals with mental health issues can and do recover. Services and supports must foster the ability for self-directed recovery. Recovery benefits not only the consumer and their family, but all the community in leading to a more healthy and productive way of life. The efforts of ADMH have been to develop and enhance a continuum of care for both adults and children/adolescents that lends itself to a flexible array of services that are focused on meeting as a first priority the needs of people with a serious mental illness and serious emotional disturbance. However, this process has to be consumer driven. Consumer driven means that consumers must have a voice in decisions that affect their lives and treatment. Consumers must have choices in the services they receive and where they live. Additionally, consumer driven means that the consumer voice must be present in planning, implementing, providing, and evaluating the services and care at a local, state, and national level. Consumer input and consumer-driven should not be confused. Input is providing comment or opinion. Driven is having an impact on the direction or course of actions. As we move toward a good and modern system of care, it will be vital to incorporate the core values: community-based, consumer-driven, family-guided, culturally and linguistically competent, and individualized.

As outlined in "Section IV-Narrative Plan M-Recovery", efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, ADMH has engaged in the following:

- Updated the ADMH Administrative Code for MI Program Standards that incorporates person centered and recovery mandates for care, as well as addressing the specialized needs of consumers who are deaf or hard of hearing.
- Utilized a regional planning process to expand consumer and family members involvement at all levels.
- Incorporated feedback from consumers and family members in ADMH planning processes which provides the foundation for ADMH's annual budget request.

- Gathered pertinent consumer feedback, to include client perception of care, through the MHSIP satisfaction survey. This data is reviewed to assist in informing the system for planning purposes.
- Continued to use Certified Peer Support Specialists within the community system.
- Initiated the use of Peer Bridgers for transitional services from state psychiatric hospitals to community settings.
- Created in-state capacity to provide Peer Support Certification training.
- Maintained funding for five existing drop-in centers.
- Submitted language related to Peer Support Services to Alabama Medicaid for consideration of a State Plan Amendment for the Rehab Option that would include Peer Support Services, Youth Peer Support Services, and Family Peer Support Services.
- Implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool.
- Received a SAMHSA Children's Mental Health Initiative System of Care (SOC) grant that covers three rural counties. This SOC met local and state level sustainability and the site will be used as a model for expansion across the state.
- Collaboration with the Alabama Medicaid Agency, Alabama Hospital Association, and the different consultants in regard to the multi-faceted areas of the Medicaid Reform process as to ensure that the mental health and substance abuse consumers we serve are being included for their unique and specialty needs for services and care.

However, ADMH has a long way to go in reaching self-directed care. There continues to be much work needed with the expansions of recovery services. Even though the above efforts are to be commended, it does not meet the needs and gaps that are necessary to build capacity for an array of services to assist with self-direction. Peer Support services are not available within each of the community mental health provider. This is not even a service that exists for children and adolescents and their families, outside a small demonstration project where there is one site in which Youth Certified Peer Specialists are being utilized in a residential setting. Drop-in centers have proven to provide engaging socialization and empowerment, but with scarce funding, there is no way for expansion without identifying new funding sources. Even though ADMH is working with Alabama Medicaid to expand service packages, it is unclear if this service could be included as a Medicaid reimbursable service. ADMH initiated the use of the CANS functional assessment tool as a means to move the system toward strength-based, individualized treatment planning process. Even though the next steps are to initiate such an instrument for adults, it has yet to occur. ADMH has financially supported the efforts of the MI Planning Council in expansion of peer services and trainings through Special Project dollars. However, with scarce funds and dwindling state dollars, concerns lie with the protection of these funds not being diverted to more traditional services.

Community Integration

An array of services must be designed to incorporate the concept of community integration and social inclusion for individuals/families. Community integration ensures that people with behavioral health problems, disabilities and other chronic illnesses have the supports and services they need to live in a home/family/community setting. This includes services to help people live in housing of their choice and support them in school, work, families and other important relationships; both paid and unpaid community supports can help achieve these goals. This will require public purchasers to take a comprehensive look at how its policies impact the way urban,

rural and frontier areas develop and how well those places support the people who live there, in all aspects of their lives—education, health, housing, employment, and transportation. This "place-based" approach should be taken to help communities work better for people.

The reforms mandated by Wyatt had a profound effect on mental illness services. The shift in emphasis from institutional care to community-based care was central to these reforms. The census at Bryce State Psychiatric Hospital dropped from over 5,000 patients in 1971 to less than 400 in 2004. Through the dedicated efforts of state psychiatric hospitals and community partners, ADMH can boast nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to present (June 2015). Over the 35 year term of the Wyatt case, a broad network of community providers evolved, and by the termination of Wyatt in 2003, the public community mental health providers served approximately 100,000 Alabamians per year with offices in all 67 counties. Since then, building a continuum of care for adults and children/adolescents within the community has been the primary focus as to develop community integration. The following are continued efforts of ADMH:

The evaluations conducted in February, 2009, revealed that there are significant numbers of state hospital extended care residents who can live in the community with adequate supports. There has been a prolonged and intensive planning process that began implementation in June, 2010. The plans called for a reduction in census at Bryce and Searcy Hospitals by creating additional community resources. The proposed reduction in state hospital census reduced the demand for extended care beds and permitted a shift of funds from state hospital budgets to needed community services. Efforts include the use of Peer Bridgers to ease the transitional process for long-term state hospital patients, expansion of housing resources such as MOM apartments, the augmentation of existing group homes to better address the needs of this specialty population, clinical support teams to provide intensive community supports that had not existed, the use of existing Certified Peer Support Specialists to enrich the community supports provided, and flex funds to tailor individualized care.

The financial atmosphere of FY11/12 and desire to advance a more responsive system of care prompted an acceleration of the Department's goals to further reduce the number of acute care psychiatric beds and to bring about the closure of some state operated facilities. The 2012 Hospital Closure Project resulted in the Department closures of Greil Memorial Psychiatric Hospital (Montgomery County) August 31, 2012 and Searcy Hospital (Mobile County) October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY11. Over ninety percent of Greil and Searcy's inpatient capacity has been shifted to local communities. As a means of supporting this shift, an innovative framework for processing inpatient commitments was born from the Hospital Closure Project. The dedicated and unprecedented cooperation between state government, local provider agencies, and local probate courts resulted in a new Department of Mental Health Commitment Procedure specifically for Regions 3 and 4 and for which the success of this project hinged. A pivotal element to the newly established commitment procedure was the development of the Gateway System which permits for the tracking of probate committed individuals to be served within the community at a Designated Mental Health Facility or Willing Hospital Participant locales.

During FY13 and FY 14, ADMH pursued a Hospital Repurposing effort in which the utilization of community inpatient capacity was further refined to supplement or supplant acute care functions at North Alabama Regional Hospital (NARH) and Bryce Memorial Hospital respectively. On July 20, 2014, patients at Bryce

Psychiatric Hospital were relocated to a new smaller state-of-the art hospital commonly referred to as the "new Bryce." As of June 17th, 2015, North Alabama Regional Hospital was closed.

Presently, the Department has a focus to move into a statewide transformation planning process that includes the process for serving committed patients, especially since the three remaining state-run psychiatric hospitals are centrally located (Tuscaloosa). The process developed will allow for continued, ongoing flexibility, customization, and movement within less restricted levels of care outside of state operated institutions.

For adolescents, much focus over the years has been on reduction of beds, going from a 40 bed unit in 2002 to currently only have a 10 bed unit. ADMH also took strides to move away from the traditional stand-alone state hospital setting for these committed youth and achieved the legal ability to contract this psychiatric hospital function, allowing committed youth to be placed in a community hospital that could address not only their psychiatric needs but their primary health needs as well. Such efforts were only achievable due to continued development of community based specialty services, such as the Juvenile Court Liaison, as well as being a direct partner with the State Multi-needs team and strong state partnerships with other child serving agencies primarily developed through the Child and Adolescent Task Force. Continued efforts will include utilizing the two sustained SAMHSA SOC initiatives to determine strategies to expand system of care values with statewide expansion opportunities.

Readmission rates are important measures of how effective discharge planning is as well as how effective reintegration is into the community. The 30 day and 180 day readmission rates are both National Outcome Measures (NOMs) and a state Performance Indicators.

ADMH remains dedicated to maintaining state policy that persons with serious mental illness (SMI) and serious emotional disturbance (SED) are served as a top priority. While the number of individuals with SMI and SED are not expected to substantially increase, it is expected that the array and intensity of services will be enhanced through the development of new services. To the extent in which public funds are expended on persons most in need, contractual requirements to serve these priority populations will continue.

Even with all the efforts highlighted above, ADMH continues to face critical needs and gaps in the system that negatively impacts community integration. For adults, there has not been a systematic statewide effort to improve employment opportunities for people with serious mental illness. However, with the recent award of the SAMHSA Supported Employment grant the seeds of addressing this gap have been planted. Adequate funding remains a challenge for all publicly supported endeavors, including mental health services. The budget cuts made over the last several years have impaired the ability to fund Permanent Supportive Housing, Peer Support Specialists, and other services designed to reduce the demand for acute state hospital beds. In fact, in FY09, 12 mental health centers lost funding for a Peer Support Specialist. The goal is to have a Peer Support Specialist at every mental health center. The availability of safe and affordable housing remains a challenge for people with mental illness and limited incomes. Finding a way to reduce hospital beds, create community resources, and save money presents a formidable challenge to an already stressed system.

For children and adolescents, ADMH has continued to make strides in developing a comprehensive system of care for children and families who struggle with Serious Emotional Disturbances (SED). Beginning in the mid-eighties, with the awarding of a federal initiative CASSP grant that facilitated the development of a system of care for children and adolescents, ADMH has gradually moved toward strategic growth of child and adolescent services through planning and resource development. In an effort to develop a continuum of care that offers an array of services at various levels of care, an emphasis has been placed on non-traditional service delivery that truly meets the needs of the consumer, family and community. Services for children and youth are complicated by developmental variables, legal status, educational requirements, health factors, cultural factors, and living situations. The presence of a serious emotional disturbance further complicates the need for and delivery of services. Ethnicity may make a significant difference in use of mental health services, as well.

Children with serious emotional disturbance and their families frequently require not only mental health services, but services from special education, child welfare, public health and/or juvenile justice. This need for multiple services from multiple agencies necessitates the integration and coordination of programs and services, not only in the service delivery arena, but also during the system planning process. As a result, the mental health system must approach service delivery from a systems perspective. Additionally, the mental health system needs to be a component of a tightly meshed overall system of care that incorporates all child caring agencies and programs.

EBP's/Best Practices

Adoption of Evidence-bases practices (EBPs) is a National Outcome measure as well as priority with ADMH. EBPs are under development in Alabama through a variety of mechanisms. There are significant gaps across the state in the availability of EBPs. For adults, there are gaps in availability of ACT and PACT teams. Less than one-half of the centers offer Permanent Supportive Housing. Seventeen centers have employed a Certified Peer Support Specialists. There has not been a systematic effort to improve employment opportunities for people with serious mental illness. ADMH has hired an Employment Specialist who will be a resource to all divisions. First Episode Psychosis (FEP) concept is just being introduced in Alabama and is beginning its infancy stages. Other adult EBPs are not being systematically implemented. Services for those experiencing co-occurring psychiatric and substance use disorders remain scarce and isolated to certain programs. EBPs for children and adolescents are not being systematically implemented at this time, primarily due to lack of funds. The MI Child and Adolescent Task Force identified and developed implementation strategies for recommended EBPs. However, the implementation is contingent on securing funding which does not currently exist. Less than 5% of what we buy conforms to national evidence-based practices (EBPs) guidelines (ACT, Supported Housing, Peer Support).

Also, the number of psychiatrists practicing in Alabama is inadequate to meet the demand in the public system. Additionally, nurse practitioners are in equally short supply. All but one of the 67 counties are designated as Psychiatric Manpower Shortage Areas. The licensing rules of the Board of Medical Examiners require that physicians moving into the state who have been out of school for more than 10 years take the general medical boards. This requirement is a disincentive for experienced psychiatrists interested in moving to Alabama. There are also restrictive parameters for nurse practitioners. ADMH was able to get a waiver for psychiatrists practicing in state hospitals and community mental health centers so that they do not have to re-take the General Medical Boards if they move from another state. This waiver

will permit a larger pool of candidates for employment in the public sector. While such an exemption will be helpful, more changes are needed in the licensing law to observe reciprocity with other state licensing bodies. To further address the shortage of psychiatrists, ADMH implemented several initiatives. ADMH has provided employment for psychiatric residents graduating from University of Alabama in Birmingham (UAB) in either a state hospital or through the community mental health centers. In the past, the Mental Illness Coordinating Subcommittee approved funding six psychiatric residency training slots – three at UAB and three at the University of South Alabama (USA). But, due to budget deficits, these funds were cut. Use of telepsychiatry offers opportunities to more effectively use existing resources. ADMH supports expansion of telemedicine capability so that existing psychiatric manpower may be more efficiently used. The Bristol-Myers-Squibb Foundation Grant provided equipment to three mental health centers which have pioneered innovative uses of the equipment, including accessing psychiatric services. Through the C&A efforts, four sites participated with a C&A Telemedicine pilot demonstration, as well. The Medicaid Agency now covers telepsychiatry services under the Physician's Program in addition to the Rehab Option.

We have sufficient information about SAMHSA-recognized EBPs. We also have interest in exploring the use of recognized Best Practices. Where we need assistance is in the large scale implementation of these practices – incorporating knowledge into practice. ADMH continues to pursue other funding avenues, such as grants and collaboration with other agencies. ADMH will increasingly rely upon EBPs and best practices to meet the needs of consumers and family members.

Section II: Planning Steps – Quality and Data Collection Readiness

Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

- The Alabama Department of Mental Health (ADMH) has collected demographic and service event data at the client level for all consumers receiving community mental health services since 1995 through the Alabama Community Services Information System (ACSIS). Client level demographic and service event data is stored in a Central Data Repository (CDR) located in the ADMH Central Office and is refreshed once a month by data uploaded electronically from each of 26 community mental health providers with whom ADMH contracts to provide services. Data can also be aggregated at the program and provider level. Each of the providers has a management information system and all have implemented or begun implementation of electronic medical record systems. Each provider has the capacity to report client level demographic and service event data to the CDR. The upload files conform to a standard file structure with data elements and standard codes specified by ADMH and required by contract. Monthly data files are uploaded using a secure ADMH website and contain. Uploads are due by the16th of the month following the month of service or a change in client profile status. ADMH has reported all required URS Tables and NOMs beginning with fiscal year 2006.
- The CARES management information system has been in use by the six state operated mental health hospitals since 1991 to track admissions, discharges, transfers, client demographics, diagnoses, and selected clinical information at the client level and is updated in real time. These two systems are linked each year using the client's Social Security Number to complete the URS tables. ADMH will implement an electronic health

record (EHR) in September 2015 in the first state psychiatric hospital which will replace CARES and allow us to continue client level reporting for the state hospital population. The EHR is expected to be operational in all three state psychiatric hospitals by June 30, 2016.

- ADMH utilizes the Alabama Substance Abuse Services Information System (ASAIS) to collect client level demographic and service event data for substance abuse services clients. Data can also be aggregated at the program and provider level. The system is a web-based system hosted by a third party and used by all substance abuse services providers. TEDS data is reported from this system. Clients from the ASAIS and ACSIS systems can be linked to report both MI and SA services. ADMH has strived to keep data element coding structures for both systems compatible to enable better reporting. A data warehouse is under development which will link mental health, substance abuse services and developmental disabilities clients served by ADMH and contain client level demographic data and service data. Funding for the data warehouse is limited, however, and progress toward this goal has been slow.

Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

- As described above, ADMH has separate data collection systems for mental health and substance abuse services.

Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

Domain	Measure Name (NQF/Block Grant)	
**Perception of Care--(Patient-Centered/ Family Involvement in Care)	**CAHPS_HEDIS** Medicaid Children; Medicaid Adult; Commercial Adult	ADMH does not collect this information from community Mental Health providers at the individual client level or the aggregate level.
**Reduced Morbidity--(Suicide)	**NQF-0104**--Major Depressive Disorder/Suicide Risk Assessment. **NQF-1364/1365**--Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	ADMH collects diagnoses at the individual client level but ADMH does not collect any information about completion of a suicide risk assessment. State hospital data will be available at the individual client level for FY17.

* Reduced Morbidity--(Suicide)	Percentage of Adults with Serious Thoughts of Suicide in the Past Year	ADMH does not collect this information from community mental health providers. State hospital data is available at the individual client level.
**Reduced Morbidity--(Decrease in Mental Health Symptoms)	**NQF-0710**-Depression Remission at 12 Months	ADMH does not collect PHQ-9 data from community Mental Health providers or state hospitals at the individual client level or the aggregate level.
**Reduced Morbidity--(Smoking Cessation)	**NQF--0028** Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	ADMH does not collect this information from community mental health providers. State hospital data is available at the individual client level.
**Reduced Morbidity-(Cardiovascular Disease)	**NQF-2602:** Controlling High Blood Pressure for People with SMI.	ADMH does not collect this information from community mental health providers. State hospital data is available at the individual client level.
**Reduced Morbidity-(Diabates)	**NQF-2603:** Diabetes Care for People with SMI: Hemoglobin A1c (HbA1c) Testing.	ADMH does not collect this information from community mental health providers. State hospital data is available at the individual client level.
**Reduced Morbidity-(ED Follow-up)	**NQF--2605**: Follow-Up after Discharge from the ED for Mental Health or Alcohol or Other Drug Dependence.	ADMH does not collect this information from community mental health providers. State hospital data is available at the individual client level.

*Reduced Morbidity (Reduced Tobacco Use Among the Population)	Reduced Tobacco Use	ADMH does not collect this information from community mental health providers. State hospital data is available at the individual client level.
**Reduced Morbidity--(Abstinence from Alcohol Use)	**NQF-2152**--Unhealthy Alcohol Use: Screening and Brief Counseling **OR** Number of Patients Identified as needing treatment for alcohol use disorder who receive treatment and significantly reduce or stop using alcohol at follow up measurement period or discharge	ADMH does not collect this information from community mental health providers or State hospitals.
*Reduced Morbidity (Underage Drinking)	Underage Drinking	ADMH does not collect this information from community mental health providers. State hospital data is available at the individual client level.
**Reduced Morbidity (Misuse of Presription Drugs)	Prescription Drug Misuse	N/A for Mental Health BG
*Reduced Morbidity (Presription Drug Misuse)	Presciption Drug Misuse	N/A for Mental Health BG
**Reduced Morbidity (Marijuana)	Marijuana Use	N/A for Mental Health BG
*Reduced Morbidity (Marijuana)	Marijuana Use	N/A for Mental Health BG
***Purpose	Employment	N/A for Mental Health BG
***Purpose	Education	ADMH does not collect this information from community mental health providers or State hospitals.
**Criminal Justice	Criminal Behavior	ADMH does not collect this information from community mental health providers or State hospitals.

*Criminal Justice	`Criminal Behavior	ADMH does not collect this information from community mental health providers or State hospitals.
Housing	Stable Housing	ADMH can report at individual client level
Homelessness	Homelessness	ADMH can report at individual client level

If not, what changes will the state need to make to be able to collect and report on these measures?

- As noted above, the only measures that ADMH is currently collecting and reporting are measures for Stable Housing and Homelessness. Criminal Justice measures are self-reported at admission, annual update and discharge and at present do not include the information required to report the measures. We are currently reporting on the NOMS measure for Criminal Justice. Adjustments would have to be made in the method of collection and the information collected to report new measures. The same is true for the Education measure. The ability to report other measures would require (1) adoption and implementation of a standard suicide risk assessment tool by the mental health community providers (2) adoption and implementation of the PHQ-9 (3) adoption and implementation of a tobacco screening instrument (5) interface with Alabama Medicaid Agency to collect data on controlling high blood pressure, diabetes care, and ED use. Note that the interface with Medicaid would not provide data on the roughly 45% of our population who are not Medicaid eligible. (6) Development of surveys to collect data not found in other state, community or local data systems. Alabama does not have a viable Health Information Exchange from which we could pull information. These measures would also require retrofitting the community mental health providers' electronic health records at a significant cost to collect and report this data to the ADMH CDR. Technical assistance in all of the above areas would be helpful.

A conservative estimate to upgrade the ADMH CDR to accommodate collection, integration and reporting of these additional measures would require a project manager for 24 months ($90,000 per year), 2 additional FTEs for programming resources for 18-24 months($75,000 per year *2 years* 2 FTE =$300, 000 and an additional FTE for data analysis and cleaning from the beginning of the upgrade forward ($65,000 per year) . The total estimate for 2 years is $610,000 which would be a 21% increase in the total current ADMH annual budget for IT. This is a definite barrier to our ability to report. ADMH is facing budget cuts for FY16 with no room for increases in IT expenditures. The best that we can hope for is level funding which does not allow for increasing IT expenditures. Again, these estimates are conservative and do not account for unpredicted areas that could unfold in the implementation process. The reality

is that for ADMH, there is no way that we can absorb these requirements into our current workload and budget without additional staff and funding.

Section III: Table 1 - Priority Area and Annual Performance Indicators

State Priorities

#	STATE PRIORITY	STATE PRIORITY DESCRIPTION/GOAL
1	Self-Directed System of Care	Design a comprehensive system of care that promotes access, choice, and satisfaction of consumers with SMI and SED, and their families, by providing effective treatment and care that is person-centered, consumer driven, and family-guided with a focus on recovery and resiliency.
2	Community Integration	Building on Olmstead and Wyatt decisions, transition or divert consumers from state psychiatric inpatient care settings to integrated community settings by using effective treatment and recovery support services designed to promote Home, Health, Purpose, and Community.
3	EBP's/Best Practices	Develop strategies to increase capacity, implementation, and sustainability of recovery supports and evidence-based/best practices.

Section II: Planning Steps –Table 1: Priority Areas and Annual Performance Indicators

PRIORITY AREA #1: Self-Directed System of Care

Priority Type: MHS

Populations: SMI, SED

GOAL: Design a comprehensive system of care that promotes access, choice, and satisfaction of consumers with SMI and SED, and their families, by providing effective treatment and care that is person-centered, consumer driven, and family-guided with a focus on recovery and resiliency.

STRATEGIES:

ADMH will:

- ***Continue to gather access data around age, gender, and racial/ethnic groups.***
- ***Maintain 80% or better of adult consumers and youth families reporting positive general satisfaction.***
- ***Maintain the percentage of adult consumers who report positively about function 77% or higher; and for family members of youth 67% or higher.***
- Hold annual Alabama Institute for Recovery training.
- Maintain five consumer operated drop-in centers.
- Continue to fund the peer services/trainings recommended by the MI Planning Council funded with Special Project dollars.
- Maintain percentage of adult and child/adolescent consumers served in rural communities at 25% of the statewide total served.
- Continue collaboration with Alabama Medicaid to pursue funding of peer services.
- Implement state-wide use of an adult strength-based functional assessment tool.
- Expand access to psychiatrist via telepsychiatry.
-

Annual Performance Indicators to Measure Goal Success

Indicator #1:

- Maintain 80% or better of adult consumers reporting positively about general satisfaction

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of adult consumers who report positive about general satisfaction = 3,732. The denominator is the number of survey responses = 4,350. (85.79%)

First-year target/outcome Measurement:

- Maintain 80%

Second-year target/outcome Measurement:

- Maintain 80%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

Indicator #2:

- Maintain 80% or better of youth families reporting positively about general satisfaction

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of youth families who report positive about general satisfaction = 743. The denominator is the number of survey responses = 854. (87%)

First-year target/outcome Measurement:

- Maintain 80%

Second-year target/outcome Measurement:

- Maintain 80%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results.

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

Indicator #3:

- Maintain 77% or better of adult consumers reporting positively about functioning.

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of adult consumers who report positively about functioning = 3,348. The denominator is the number of survey responses = 4,244. (78.89%)

First-year target/outcome Measurement:

- Maintain 77%

Second-year target/outcome Measurement:

- Maintain 77%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

Indicator #4:

- Maintain 67% or better of family members of youth reporting positively about functioning.

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of youth family member who report positively about functioning = 613. The denominator is the number of survey responses = 850. (72.12%)

First-year target/outcome Measurement:

- Maintain 67%

Second-year target/outcome Measurement:

- Maintain 67%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

Indicator #5:

- Maintain percentage of adult consumers served in the rural areas of the state at 25% of the statewide total served.

Baseline Measurement:

- Initial data collected during FY14. The numerator is total rural SMI served = 19,150. The denominator is the total SMI served statewide = 58,163. (32.92%)

First-year target/outcome Measurement:

- Maintain 25%

Second-year target/outcome Measurement:

- Maintain 25%

Data Source:

- The ADMH Central Data Repository. US Bureau of Census.

Description of Data:

- Services to the CDR. Rural communities identified through the US Bureau of Census

Data issues/caveats that affect outcome measures:

Reduction in funding could also reduce access to services and decrease in service staff.

Indicator #6:

- Maintain percentage of children/adolescent consumers served in the rural areas of the state at 25% of the statewide total served.

Baseline Measurement:

- Initial data collected during FY14. The numerator is total rural SED served = 7,687. The denominator is the total SED served statewide = 25,334. (30.34%)

First-year target/outcome Measurement:

- Maintain 25%

Second-year target/outcome Measurement:

- Maintain 25%

Data Source:

- The ADMH Central Data Repository. US Bureau of Census.

Description of Data:

- Services reported to the CDR. Rural communities identified through the US Bureau of Census

Data issues/caveats that affect outcome measures:

Reduction in funding could also reduce access to services and decrease in service staff.

PRIORITY AREA #2: Community Integration

Priority Type: MHS

Populations: SMI, SED

GOAL: Building on Olmstead and Wyatt decisions, transition or divert consumers from state psychiatric inpatient care settings to integrated community settings by using effective treatment and recovery support services designed to promote Home, Health, Purpose, and Community.

STRATEGIES:

ADMH will:

- ***Maintain the rate of admission to state psychiatric facilities within 30 days of discharge at or below 5% for adults and adolescents; within 180 days of discharge at or below 13% (excluding forensic patients) for adults; and within180 days of discharge at or below 10% for adolescents.***
- ***Continue/expand services, as well as collaborate with state and local partners, in an effort to support consumers seeking and retaining competitive employment.***
- ***Continue/expand services, as well as collaborate with state and local partners, to promote increased school attendance and positive school involvement.***
- ***Continue/expand services, as well as collaborate with state and local partners, to promote reduction in criminal justice/juvenile justice involvement***.
- ***Continue/expand services, as well as collaborate with state and local partners, to promote stability in housing within the community and expand access to community housing options as well as reduce homelessness.***
- ***Maintain positive responses to social connectedness for adult and child/adolescent consumers.***
- Implement approved regional community service development plans in an effort of repurposing the use of state psychiatric hospitals.
- Develop infrastructure for Peer Recovery Services to include, but not limited to, certification, training, service expansion, and funding mechanisms.
- Continue contract requirement to serve adults with SMI and children/adolescents with SED.

Annual Performance Indicators to Measure Goal Success

Indicator #1:

- Increase/Maintain Employment

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of adult consumers who were employed = 5,943. The denominator is the number of adult consumer reporting on employment = 65,580. (09%)

First-year target/outcome Measurement:

- Maintain FY14 Baseline

Second-year target/outcome Measurement:

- Maintain FY15 Baseline

Data Source:

- URS Table 4

Description of Data:

- Central Data Repository and URS tables

Data issues/caveats that affect outcome measures:

- Due to the economic climate, employment is vastly impacted and difficult to predict particularly for our target populations.

Indicator #2:

- Improvement in school attendance

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of youth families who reported improvements in child's school attendance = 143. The denominator is the number of survey responses = 465. (30.75%)

First-year target/outcome Measurement:

- Maintain FY14 level.

Second-year target/outcome Measurement:

- Maintain FY15 level.

Data Source:

- URS Table 19b

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

- No issues foreseen that will affect the outcomes.

Indicator #3:

- Decrease criminal justice involvement

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of adult consumers who reported decrease in criminal justice involvement = 609. The denominator is the number of adult consumer survey responses = 981. (62.08%)

First-year target/outcome Measurement:

- Maintain FY14 level.

Second-year target/outcome Measurement:

- Maintain FY15 level.

Data Source:

- URS Table 19a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

Indicator #4:

- Decrease juvenile justice involvement

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of youth who reported decrease in juvenile justice involvement = 60. The denominator is the number of survey responses = 107. (56.07%)

First-year target/outcome Measurement:

- Maintain FY14 level.

Second-year target/outcome Measurement:

- Maintain FY15 level.

Data Source:

- URS Table 19a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

Indicator #5:

- Increase stability in housing

Baseline Measurement:

- Initial data collected during FY14. The percentage of adults who report being homeless in FY14 will be less than 2% of the total adults served. The numerator is number of consumers reporting homeless/shelter at end of FY14 = 881. The denominator is 64,027. (1.38%)

First-year target/outcome Measurement:

- Less than 02% homeless/shelter

Second-year target/outcome Measurement:

- Less than 02% homeless/shelter

Data Source:

- The ADMH Central Data Repository

Description of Data:

- Consumer profile demographic data collected at admission, annual review, and discharge

Data issues/caveats that affect outcome measures:

Due to the economic climate, employment is vastly impacted and difficult to predict particularly for our target populations.

Indicator #6:

- Increased Social Connectedness for adult consumers

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of adult consumers who report increased social connectedness = 3,195. The denominator is the number of survey responses = 4,219. (75.73%)

First-year target/outcome Measurement:

- Maintain FY14 baseline

Second-year target/outcome Measurement:

- Maintain FY15 baseline

Data Source:

- URS Table 9

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

Indicator #7:

- Increased Social Connectedness for families of youth consumers

Baseline Measurement:

- Initial data collected during FY14. The numerator is the number of youth family members who report increased social connectedness = 613. The denominator is the number of survey responses = 840. (82.98%)

First-year target/outcome Measurement:

- Maintain FY14 baseline

Second-year target/outcome Measurement:

- Maintain FY15 baseline

Data Source:

- URS Table 9

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

PRIORITY AREA #3: EBP's/Best Practices

Priority Type: MHS

Populations: SMI, SED

GOAL: Develop strategies to increase capacity, implementation, and sustainability of recovery supports and evidence-based/best practices.

ADMH will:

- Maintain funding for ACT/PACT, Permanent Supportive Housing, and Certified Peer Support Specialists.
- Maintain the number of Permanent Supportive Housing units.
- Maintain the 16 ACT and 2 PACT teams currently funded.
- Maintain the number of employed Certified Peer Support Specialists.
- Continue/expand the child and adolescent (C&A) EBP of CPS and SBMH.
- Implement FEP through the technical assistance provided by SAMHSA.
- Continue collaboration with Medicaid around restructuring, expanding, and/or transforming payment and service delivery structures to fund EBPs.
- Increase telehealth capacity.

Annual Performance Indicators to Measure Goal Success

Indicator #1:

- Maintain funding for Supported Housing slots

Baseline Measurement:

- Initial data collected during FY14. Funding for continuation of supported housing slots will be maintained at FY14 level = 324.

First-year target/outcome Measurement:

- Maintain FY14 level

Second-year target/outcome Measurement:

- Maintain FY14 level

Data Source:

- MICRS. CDR

Description of Data:

- ADMH maintains a web-based residential reporting system where the Supported Housing units are reported in addition to reporting data in the CDR.

Data issues/caveats that affect outcome measures:

- No issues foreseen that will affect the outcomes.

Indicator #2:

- Maintain the number of employed Certified Peer Support Specialists

Baseline Measurement:

- Initial data collected during FY14. 45 Certified Peer Support Specialist (CPS) are employed at community mental health centers

First-year target/outcome Measurement:

- Maintain 45 CPS.

Second-year target/outcome Measurement:

- Maintain 45 CPS

Data Source:

- Office of Consumer Relations

Description of Data:

- Information collected by the Office of Consumer Relations. Provider self-report. Certification site visits.

Data issues/caveats that affect outcome measures:

- Reduction in funding could cause less access in services and decrease in service staff.

Indicator #3:

- Implement the First Episode Psychosis (FEP) team in one site

Baseline Measurement:

- Baseline measurement for this number will be 0 as there is not currently the implementation of FEP team.

First-year target/outcome Measurement:

- Implementation of training to staff of at least one demonstration site to provide FEP to efficacy of the model.

Second-year target/outcome Measurement:

- Implementation of FEP team serving consumers to the efficacy of the model.

Data Source:

- Certification site visits and CDR

Description of Data:

- CDR

Data issues/caveats that affect outcome measures:

- Reduction in funding could also reduce access to services and needed resources.

			b.	c.	d.	e.	total
table2			bg	mcd	other fed	state	
5	State Hosp		0	11,221,670	9,268,993	66,405,626	86,896,289
6	residential		4,246,037	0	0	41,179,332	45,425,369
7	other		1,156,137	126,364,180	1,913,800	97,574,722	227,008,839
8	prevention		724,075	0	0	0	724,075
9	MH EBP 5%		333,040				333,040
	Total Community		6,459,289	126,364,180	1,913,800	138,754,054	273,491,323
10	Admin		201,510	195,070	94,010	2,582,168	3,072,758
11	Total MI		6,660,799	137,780,920	11,276,803	207,741,848	363,460,370
table 6b	t/a		0				
	planning council		550,600				
	admin		201,510				
	data collection		0				
	enrollment		0				
	other activities		1,214,115				
	total		1,966,225				
table 3	services		4,694,574				

Section IV: Environmental Factors and Plan: 1. The Health Care System and Integration

Despite previously supporting Alabama's implementation of a state-based health insurance exchange, Governor Robert Bentley announced on November 13, 2012, the state will default to a federally-facilitated exchange. The federal government will assume full responsibility for running a health insurance exchange in Alabama beginning in 2014.

Also, Governor Bentley announced in November of 2012 that Alabama would not participate in Medicaid expansion because of funding. Governor Bentley did not believe the Affordable Care Act was a "workable solution," and reaffirmed his stand against accepting a federal offer to expand Medicaid in the state. Governor Bentley has indicated that he doesn't want to expand a broken system. He is optimistic that Alabama Medicaid reform, which he signed into law in June 2013, will go a long way toward the solutions needed in Alabama. The reform employs a managed care overlay to the system, in hopes of greatly reducing costly medical encounters by Medicaid users.

In December 2014, Governor Bentley suggested that he might be open to an alternative option for expanding Medicaid in Alabama. Governor Bentley had previous opposed expanding the state-federal insurance program, but he says creating a state-designed program that uses the federal Medicaid expansion dollars may be an option for his state at some point, especially as Medicaid Reform progresses within the state of Alabama. At present date, Medicaid Expansion has not occurred on Alabama.

As discussed within this application, Alabama is in the process of Medicaid Reform and the future of Medicaid and potential changes in its payment structures and/or services provided is unknown. Due to the infancy of the process with the implementation of these processes, the many of the questions above cannot be fully answered. It is important to note that ADMH has a longstanding working relationship with the Alabama Medicaid Agency and other state agencies directly involved with both processes. ADMH has been and will continue to be directly involved with making recommendations on the decision making processes. Representatives from ADMH participate on the multi-level committees and workgroups including the Commissioner of ADMH and his designated staff.

ADMH does not have a plan for monitoring whether individuals and families have access to mental health and substance use/abuse services offered through QHPs and Medicaid. Any monitoring responsibilities in regard to activities of the QHPs falls within the authority of the Alabama Department of Insurance. At the present time, ADMH will only be involved if authorized by the Governor, and if assistance by the Alabama Department of Insurance and/or Attorney General is needed in this regard.

Currently, much focus in Alabama is on Medicaid Reform. The Alabama Legislature has authorized the state's Medicaid agency to establish Regional Care Organizations (RCOs) to manage all physical and behavioral health services for Medicaid beneficiaries. As this process unfolds, ADMH, as the SSA for mental illness and substance abuse services, wants to make sure that the needs of individuals who have behavioral health disorders are appropriately addressed by the RCOs. With this process, there is a high focus on care coordination. ADMH is currently and plans to continue to primarily participate will all levels of care coordination as it pertains to any initiatives such as Medicaid Reform, Health Homes, Money Follows the Person, and MEPD Project. ADMH and Medicaid meet routinely to plan for this behavioral health/physical health care integration initiative. For more detailed information in regard to coordinated care initiatives, please review Section IV: Environmental Factors and Plan: 21. Support of State Partners

A gain in momentum to address nicotine dependence among individuals with mental health disorder over the past decade has occurred within the state hospital settings. The state hospitals became tobacco-free on January 1, 2010. All state hospitals are currently smoke-free and interventions to assist consumers with this process have been implemented. For the contracted community mental health centers, there has been progress with initiation of individual endeavors to address smoking cessation, but ADMH has not implemented a state-wide process to address this issue.

Consumers who are in state hospitals are provided medical care as part of their involuntary confinement where there is no insurance or other source of coverage for medical expenses.

Consumers who have no health insurance and who reside in ADMH community residential programs have minor medical services paid by the provider. There is a limited statewide fund for residents of foster homes to pay for incidental medical expenses when there is no other source of revenue.

Most of the adults with serious mental illness and youth with serious emotional disturbances have Medicaid coverage for medical and dental services. For consumers who are Medicaid or Medicare eligible, almost every type of medical care is provided. Very often the only barrier to service is finding providers who serve Medicaid consumers. Other, non-Medicaid eligible clients have typically exhausted health care resources such as insurance, and must rely on health care available in their community on an indigent basis. Typically, local Public Health departments and community health clinics are the main referral resources used by case managers to meet the primary health care needs of their consumers. Local hospitals provide a very limited amount of inpatient care to indigent consumers. Because of historical practices among indigent consumers, many emergency rooms provide the only primary health care some consumers get. Individuals with mental illness have wrestled with the health care issue for years and in general this is one of the few areas where children and adolescents fare better than the adults. For example, Medicaid benefits for persons under 21 can exceed usual limits when indicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Children and adolescents in the care of DHR and DYS receive medical care from these agencies, as well as through school nurses where available. In addition to coverage by Medicaid, dental services are covered by ALL Kids, Alabama's SCHIP program. Case managers provide a vital service by linking consumers to individual practitioners who will accept Medicaid or who will agree to see consumers on a sliding scale or no fee basis.

Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

Access to dental care is often cited as an unmet need for consumers. The University of Alabama in Birmingham School of Dentistry also provides free clinics around the state. The waiting list for these clinics is very long. Case managers assist consumers in getting on the waiting list for any available free clinics. In some areas of the state, local dentists volunteer time for free clinics. Again, the amount of time and the range of services are limited.

In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, the Department has promoted health and wellness education and activities. During the last several years, the annual Alabama Institute for Recovery has

provided a platform for conducting wellness screenings for a significant sample of consumers in attendance from all over the state. The 2015 Alabama Institute for Recovery had approximately 90 consumers to volunteer for screenings. Screening methods included checking blood pressure for hypertension, body mass index for obesity, and blood glucose for diabetes. Due to restrictions in funding, no lipid tests were conducted to check for high cholesterol. ADMH acknowledges that research suggests smoking prevalence among U.S adults with mental illness or serious psychological distress ranges from 34.3% (phobias or fears) to 88% (schizophrenia). This was the third year in which the Fagerstrom Index was utilized to screen for nicotine dependence. Screenings were provided in partnership with Pfizer. The results of the screenings show a high degree of co-morbidity with diabetes, obesity, and hypertension. Health information and smoking cessation information was disseminated at this event.

Section IV: Environmental Factors and Plan: 2. Health Disparities

All community level data are collected at admission, annual update, and discharge. At or near the anniversary data of admission to the service, the client's individual profile records are updated and uploaded to the ADMH Central Data Repository. The data currently captured with demographics includes race, ethnicity, age, and gender (excluding transgender). It is important to note there is a requirement that providers report on hearing status of all consumers in general demographics (rather than "medical conditions" or Axis III). This readily allows ADMH to track consumers who are deaf or hard of hearing and target resources in an efficient manner. This allows ADMH to pinpoint and define the consumer characteristics of the 1,787 hard of hearing people and 200 deaf people that received services from ADMH in FY14.

ADMH has established an Office of Deaf Services (ODS) to serve deaf and hard-of-hearing Alabamians better. ADMH is committed to ensuring that their peers will design programs for deaf and hard-of-hearing persons to ensure services are linguistically accessible and culturally affirmative, giving the consumer every opportunity to make progress to recovery. The ODS staff includes a director, statewide services coordinator, a statewide mental health interpreter coordinator, statewide and regional clinical staff, and regional communication access team members. ODS also provide significant communication and clinical support to Bryce, where deaf people needing inpatient care are served. ADMH has developed specific standards of care for people with hearing loss that includes, among other things, specific requirements for measurable fluency in American Sign Language for certified community programs which work with deaf consumers. Also, through contracts with ADMH, the contracted providers have access to language interpreters regardless of language and those services to assist with language needs as needed in services and care. (See attached ODS FY14 Annual Report)

Also in ADMH MI Program standards, providers are to provide services that are culturally competent and linguistically competent and represents the ethnic and gender needs of the community. In FY14, ADMH and providers began capturing data on the client's primary language to facilitate meeting linguistic needs of our client populations. At present, we do not capture data on transgender, sexual orientation, or tribal connection but will explore including these data elements in our data

ADMH will continue to share data information with our providers and other stakeholder entities to include National Outcome Measures (NOMS) and results from MHSIP Satisfaction Surveys and CANS results. Funding through the Behavioral Health Services Information System State Agreement (BHSIS) has been utilized to assist with measuring, tracking, and responding to disparities in the ongoing development of a data warehouse for mental health and substance abuse services data.

Section IV: Environmental Factors and Plan: 3. Use of Evidence in Purchasing Decisions

ADMH has a developed process for dissemination of information within ADMH between the services divisions and ADMH specific offices. With the Divisions, primarily the program staff disseminates pertinent information, especially regarding evidence-based or promising practices. ADMH distributes information with external sources, such as the members of the MI Planning Council, Mental Illness Coordinating Sub-Committee, and MI Child and Adolescent Task Force, as well as to the provider network and state-wide consumer and family advocacy networks. This is done through list serve/distribution emails.

Many different elements of information are used in the purchasing and policy decisions involving evidence-based or promising practices. The following EBPs are in various phases of development in Alabama.

- Assertive Community Treatment (ACT)
- Integrated Treatment for Co-Occurring Disorders (COD)
- Permanent Supportive Housing
- Supported Employment
- Peer Support Services
- Coping Power
- School-Based Mental Health Collaboration
- First Episode Psychosis (FEP)

Information used was from notifications sent out by SAMHSA, NASMHPD, and other national and state entities. From the SAMHSA website, two sources that were used were the Evidence-Based Practices Tool Kits and A Guide for Selecting and Adopting Evidence-Based Practices for Children and Adolescents with Disruptive Behavior Disorders.

The information on evidence-based and promising practices have been distributed and utilized within the previously discussed committees, councils, and task forces. In all these planning groups, there are representatives from Medicaid, S-Chip, and other purchasers. In particular to mental health children and adolescent, the Child and Adolescent Task Force developed a workgroup to assist in the guidance and recommendations of evidence-based and/or promising practices (See Section II. Step 1 for more detailed information on both adult and child/adolescent EBPs)

Evidence-Based and promising practices are part of the considerations taken into account in purchasing services. Much of the purchasing decisions are made with the Regional entities and the individual community mental health centers. Each community mental health center is expected to

develop and manage a comprehensive array of mental health services with sufficient capacity for designated geographic areas.

Section IV: Environmental Factors and Plan: 4. Prevention for Serious Mental Illness

It is our understanding that this section is for providing information. Alabama is aware of the requirement of the set aside of 5 percent to provide treatment to those with early SMI and have begun the initiation of First Episode Psychosis (FEP). ADMH and the Mental Illness Planning Council (MIPC) realized that we needed more direct technical assistance and requested this through the SAMHSA TA Tracker. In January 2015, ADMH was notified that the formally requested TA was approved and ADMH started working with NASMHPD to determine the best avenue to achieve our request and meet the needs of our state for implementation of FEP. Alabama was linked to direct TA with the Early Assessment and Support Alliance (EASA) Center of Excellence through Portland State University in Portland, Oregon and began consultation with Tamara Sale, Director of EASA.

For more information on where Alabama is in the process of implementation of FEP, see refer to Section IV: 5. Evidence-Based Practices for Early Intervention (5 Percent)

Section IV: Environmental Factors and Plan: 5. Evidence-Based Practices for Early Intervention (5 Percent)

When Alabama was notified about the requirement of the set aside of five percent to provide treatment to those with early SMI, Alabama began trying to gather information on how to successfully meet these requirements, to include participating with SAMHSA hosted webinars, review of literature, etc. The MI Planning Council took high interest and leadership to ensure that this Evidence-based practice was appropriately implemented in Alabama. Since it was unknown if a program for First Episode Psychosis (FEP) exists in Alabama, the first step in the process was to develop initial capacity for FEP specialty care.

Alabama decided to utilize the MI Planning Council (MIPC) members as the stakeholder group as it consists of consumers, family members, and providers. The membership has diversity of expertise that includes working with adolescents and adults. This MIPC focused on the following areas as the process was initiated:

- Take inventory of what EBP programs that focus on First Episode Psychosis may exist in Alabama. We also explored the models across the nation, such as the RAISE programs that have been introduced to us through the SAMHSA webinars as well as other programs such as FIRST in Ohio, OASIS in North Carolina, and EASA in Oregon.
- Determine the eligibility criteria for the proposed target population and define the explanation for why this population was chosen.
- Determine pilot site location. We plan to start with one pilot site that would have the ability to implement a single program that adheres closely to the Coordinated Specialty Care (CSC) principles. With the implementation of this pilot site, as a first step, we will evaluate the ability to leverage existing clinical and administrative resources that might serve as a platform for developing as integrated CSC program for youth/young adults with FEP. To achieve this, we will explore agencies that have experience in offering team-based

treatment that would include ACT teams and Child and Adolescent In-Home Intervention, as well as have utilized Certified Peer Specialists in a recovery model. This determination will include evaluating agencies that may have core CSC services readily available and a willingness for organizational restructuring with ongoing consultation with FEP experts to assess the need to repurpose existing services into an integrated, team-based CSC treatment program, as well as administrative changes that may be needed to facilitate the integrated delivery of services.

- Develop a training plan that meets the fidelity to the model. Through this process, we will explore resources through universities, as well as the developed training materials from other FEP models across the nation. In order to enhance fidelity to the chosen model, workforce development also involves ongoing supervision and continuing education for all staff involved in the treatment program.
- Assure the fidelity of the model is implemented. Fidelity monitoring must address the needs of the consumers and their families being served as to assure that services offered are of satisfactory quality and lead to desired school, work, and health outcomes. We will explore the use of electronic health records (EHR) to assess the ability of allowing fidelity and outcome information to be obtained from electronic claims data or other automated reports.
- Data collection will be implemented for evaluation process. As we explore and determine what FEP program that will be implemented, we will assess what other programs are collecting with data elements. We will utilize existing data elements collected as to enhance the process. We will seek additional technical assistance and guidance on the expectation for data collection and reporting as this is determined by SAMHSA.
- Development of budget. This will need to include determining costs to include, but not limited to, training, infrastructure building, program determination, and pilot demonstration implementation. We will assess the ability to leverage funds through inclusion of services reimbursed by Medicaid and private insurance.
- Utilize technical assistance and technical resources provided. We will continue to work with SAMHSA and other resources to ensure the use of technical assistance and technical resources that will be available to states for the development and implementation of our plan.

As we moved into FY15, ADMH and the MIPC realized that we needed more direct technical assistance and requested this through the SAMHSA TA Tracker. In January 2015, ADMH was notified that the formally requested TA was approved and ADMH started working with NASMHPD to determine the best avenue to achieve our request and meet the needs of our state for implementation of FEP. Alabama was linked to direct TA with the Early Assessment and Support Alliance (EASA) Center of Excellence through Portland State University in Portland, Oregon and began consultation with Tamara Sale, Director of EASA. Through this formal technical assistance, ADMH and the MIPC were able to complete the following:

1. Determine the assessed need for the target population:
   a. The target population is individuals experiencing the early stages of schizophrenia or schizoaffective disorder in Birmingham, Alabama. Based on Birmingham's population of just over 212,000 and a conservative annual incidence rate estimate

of between 1.5 per 10,000 population, we estimate approximately 32 new individuals per year entering the program.

2. Explain why this population was chosen:
    a. This population was chosen for the following reasons:
        i. Individuals with schizophrenia and related conditions have been well-documented to have poor access to evidence-based care and poor short-term and long-term outcomes.
        ii. The evidence base associated with early psychosis intervention has focused primarily on schizophrenia and related disorders.

3. Identify a specific diagnostic category (i.e. psychosis, schizophrenia, bipolar, etc.) for the targeted population:
    a. Schizophrenia and schizoaffective disorder

4. Clarify where Alabama is with the implementation of FEP at the close of FY15:
    a. Alabama will work with the Oregon Early Assessment and Support Alliance (EASA) Center for Excellence and other trainers as needed to implement the following specific programs:
        i. Coordinated specialty care delivered by a team including masters-level clinicians, psychiatry, nursing, supported employment and education, substance abuse treatment, peer support and possibly occupational therapy.
        ii. Service elements including community education, rapid outreach, flexible engagement, comprehensive assessment and individualized treatment planning, individual and family psychoeducation, individual counseling including cognitive behavioral therapy and motivational interviewing, psychiatry using a low-dose protocol, feedback-informed treatment, and transitional processes. Alabama will work with Oregon to adapt their model.

5. Clarify the status of the development of a budget showing how the 5% will be spent.
    a. At the closure of FY15, the budget had not yet been completed but is on course to be finalized in the next 3 months.

EASA will have their first on-site technical assistance the first week of September 2015. The TA will lead ADMH and the MIPC into determining the implementation and development of the budget to support the implementation of FEP. Alabama will contract with EASA in FY16 for continued consultant and implementation. (See attached FEP training brochure and agenda).

Section IV: Environmental Factors and Plan: 6. Participant Directed Care

It is our understanding that this section is for information purposes and not a requirement. At this time, Alabama is not interested in implementing a voucher system.

Section IV: Environmental Factors and Plan: 7. Program Integrity

Since Alabama will not implement its own health exchange, the state may not have progressed as far as other states in planning for Affordable Care Act implementation.

The program integrity process involves a number of ADMH administrative tools including the ADMH MI Program Standards, ADMH Administrative Division Finance Bureau Audit Guidelines Manual, ADMH contracts, and ADMH Mental Illness Contract Service Delivery Manual. ADMH expends most of the Community Mental Health Services Block Grant (MHBG) through the community mental health centers and state-wide consumer/family advocacy entities. ADMH policy on the use of state and federal funds is expressed in the above listed tools.

The ADMH MISA Services Division conducts on-site visits as indicated in ADMH MI Program Standards (administrative code) for all programs certified either as a community mental health center or as a community mental health provider. The purpose of these on-site certification reviews is to evaluate program plans and services delivered to ensure consistency and conformance with services definitions, state regulations, and policies governing mental health programming. The on-site certification reviews are conducted every two years or sooner.

Under the FY16 contracts, ADMH expects the centers to develop and manage a comprehensive array of mental health services with sufficient capacity as outlined in ADMH MI Program Standards. In developing and managing this continuum of services, the centers are expected to include in their planning the federal mandates under the SAMHSA Mental Health Block Grant (MHBG). Within the contracts, language exists that outlines that the contractor has an affirmative responsibility to pursue any third party payment (e.g., Medicaid, Medicare, etc.) and that ADMH is the payor of last resort. The contract also outlines that the contractor agrees it will comply with all applicable terms, conditions, provisions, and requirements delineated in the current ADMH Audit Guidelines Manual and subsequent amendments.

MHBG budget review monitoring and oversight responsibilities on the state budget appropriation level are primarily assigned to the staff within the ADMH Bureau of Finance, primarily the office of accounting. The Bureau of Finance manages the accounting, financial reporting, budgeting, purchasing, payroll, and accounts payable functions for the department. In addition, it is responsible for the financial management of the department's contracts and federal awards. The assigned staff provides quarterly projections of MHBG award balances to ADMH MISA Division MI Financial Data Analysis.

A funding plan for the MHBG is reviewed annually with the MI Planning Council. In addition, the same funding plan is reviewed and approved by the Associate Commissioner of ADMH MISA Services Division. Any substantial change in these plans are also reviewed and approved by the same parties. The Division has also developed a standard uniform excel budget sheet for all contracts awarded under the MHBG. These individual budgets are reviewed and approved by the MI Financial Data Analyst, Director of MI Community Programs, Associate Commissioner of the Division, and ADMH Office of Accounting. The purpose of the review is to assure that all contract expenditures as described in narrative format, are consistent with the purpose of each contract, the planned expenditures Block Grant requirements and rules.

Alabama does not use insurance claims model for distributing Block Grant funding. Instead individual contracts are utilized to distribute block grant funding. Questions of payment processes under these contracts are addressed by Division managers, ADMH Bureau of Finance staff, and Division's Financial Data Analyst.

On a quarterly basis, the ADMH's Office of Accounting produces an excel spreadsheet summary of the financial status of all block grant-funded contracts that is distributed to the MI Financial Data Analyst and Director of MI Community Programs. The report notes if individual block grant contracts have failed to expend funding in a timely manner. On a quarterly basis, the ADMH Office of Account updates obligation spreadsheets that detail the planned contract and operational expenditures for each block grant award, the contracts obligated and contracts expended. These obligation spreadsheets are reviewed by the Division's MI Financial Data Analyst, Director of MI Community Programs, and Associate Commissioner. Utilization and performance analysis reports are created to analyze block grant funded agency. These reports are reviewed by the providers, the Division MI Financial Data Analysis, and the Division Director of MI Community Programs.

Agencies receiving block grant contract awards of $500,000 or more are required to submit single audit reports to Department staff that include a review of adherence to federal block grant requirements on an annual basis. These agencies are responsible for resolving audit findings, questioned costs, practices, etc., in accordance with applicable laws and regulations (e.g., Single Audit Act, OMB Circular A-133, Medicaid requirements,), and/or to ADMH's satisfaction within six (6) months from the issue date of the respective report(s). This same responsibility and resolution period apply to the entity for any/all audit findings, questioned amounts, and/or practice of the entity's subcontractors/recipients that received funds through any ADMH contract, grant, and/or agreement. ADMH has oversight responsibility to coordinate and ensure that all audit findings and questions that could or do affect ADMH funding are satisfactorily resolved within the required time limit. These reports are reviewed by personnel in the ADMH Office of Contracts under the Bureau of Finance. Any findings of significance are passed along to Division's MI Financial Data Analyst. These findings are discussed with the Director of MI Community Programs and the Division's Associate Commissioner. Appropriate ADMH staff lead an investigation of the findings and develop a corrective action or response plan. If the agency succeeds in adequately addressing the finding issues and is approved, the Commissioner has final authority only within ADMH on the resolution of all audit findings. The details of the process are outlined in the ADMH Administrative Division Finance Bureau Audit Guidelines Manual.

The Division has concentrated the majority of its MHBG funding on non-direct services other 24 hour care. In addition, the primary focus of funding for direct services under the MHBG is serving populations that are not likely to be eligible for Medicaid or private insurance eligible and/or would not have the services paid through ADMH support paid by Medicaid or private insurance. As the Affordable Care Act is implemented, ADMH will evaluate its monitoring tools and determine appropriate adjustments to the new health insurance coverage expectations.

Section IV: Environmental Factors and Plan: 8. Tribes

Alabama is home to only one federally recognized Indian Tribe. Operating as a sovereign nation since 1984, the Poarch Band of Creek Indians consists of descendants of a segment of the original Creek Nation which once covered almost all of the state, as well as, Georgia. The Poarch Creeks have lived together for almost 200 years in and around the reservation, which is located fifty-seven (57) miles from Mobile in Poarch, Alabama.

The Alabama Department of Mental Health (ADMH) does not currently have ties with the Poarch Band of Creek Indians, but understands the significance and value of pursuing such. Under our previous administration, ADMH attempted to establish and implement an ongoing relationship with the Poarch Creek Indian Tribe as to enable regular, meaningful, government-to-government consultation and collaboration in the areas of planning, operating, and funding substance abuse and mental health services in Alabama. To date, the Poarch Creek Tribal Leaders have not responded to ADMH.

ADMH is dedicated to continue efforts in establishing and implementing an ongoing relationship with the Poarch Creek Indian Tribe but guidance and technical assistance will be needed to achieve this endeavor.

Section IV: Environmental Factors and Plan: 9. Primary Prevention for Substance Abuse

Not Applicable for MI Block Grant. Please refer to the SA Block Grant Application for this section.

Section IV: Environmental Factors and Plan: 10. Quality Improvement Plan

During FY 15, the Alabama Department of Mental Health, Division of Mental Health and Substance Abuse Services, revised the state CQI Plan to encompass substance abuse services and mental health services. The combined state CQI Plan streamlines the reporting requirements, helps to ensure valid and reliable data, and incorporates all stakeholder input in measuring the effectiveness and quality of services received by the consumers we serve. The State PI Committee now includes stakeholders that represent Substance Abuse programs, both inpatient and outpatient, Medication Assisted Treatment Programs, Family members, and other Substance Abuse Advocacy Groups. The Committee now reflects broad representation for both MI and SA treatment services. In addition, the Division of Mental Health and Substance Abuse Services has recently moved to an electronic incident reporting system. The online system encourages timely, accurate incident reporting and enables providers to access their data to review for potential service quality improvement activities. By establishing these standards and processes, the Office of Performance Improvement is better able to assess the quality of services provided, track critical outcomes, and identify trends in community care settings. In FY 15, the MI Performance Improvement Committee met four times to review data and conduct PI business. Community Provider data that was reported and reviewed through the ADMH Performance Improvement Process includes Safety measures (critical incidents), Rights measures (complaints, grievances, and abuse/neglect allegations), Continuity of Care measures, and Outcome measures. The current active community provider PI measures are listed in Appendix

B of the attached State CQI Plan. The Safety measures listed below are reported to the ADMH in accordance with the published *Alabama Department of Mental Health, Division of Mental Health and Substance Abuse Services, Procedures for Reporting Incidents and/or Critical Incidents in Certified Community Programs.* (currently under revision). These procedures describe the process for responding and reporting incidents and/or critical incidents. The Alabama Administrative Code also includes requirements for responding to complaints and grievances in accordance with the ADMH Internal Advocacy Program.

The following outlines the measures that were reported/reviewed each quarter/annually for the MI Community Programs:

Safety Measures

Death

Injury

Suicide attempts

Seclusion/Restraint use and any associated injuries

Medication Errors

Elopements

Rights Measures

Abuse/Neglect Allegations

Advocacy Monitoring (complaints/grievances/rights violations)

Continuity of Care Measures

30 Day Readmissions to State Hospitals

Hospitalization

Tracking of Continuing Care Plans (Hand-off communication from state hospitals)

Outcome Measures

Certification/standards compliance

Adult/Family Consumer Perception of Care/Quality of Life (MHSIP Surveys - Annual Measures)

The following outlines the key Community performance improvement initiatives for the Committee this year:

- Adding the capability for providers to electronically report seclusion/restraint data into the existing electronic reporting system and expanding the seclusion/restraint indicator to include location of seclusion/restraint event by program type. The PI Committee members have requested that the seclusion/restraint data be reported by Adult vs Child/Adolescent, program type, the number of restraints, the number of seclusions, the number and level of injury associated with seclusion episodes, the number and level of injury associated with restraint episodes.

- Providing regional PI training for all certified providers

2015 MHSIP Survey Process (Consumer Satisfaction Surveys)

The MI PI Committee provided oversight to the Community MHSIP Survey process which was conducted for the thirteenth time in May of 2015. Physical health questions and substance use questions were added to the Adult MHSIP and Youth Family surveys in 2010. The addition of these questions has provided additional consumer data to be used to better address the physical and behavioral needs of consumers. A total of twenty seven (27) agencies participated in the 2015 MHSIP Survey Process. The Adult MHSIP, Adult Family, Life Satisfaction, Youth Services, and Youth Services Family surveys were administered May 4, 2015 through May 15, 2015. The results for each of the following surveys will be available by September 30, 2015:

Adult MHSIP

Adult Family

Life Satisfaction

Youth Services Survey

Youth Services Family Survey

The 2015 individual center survey results (as well as state and national comparison data) will be distributed to each CMHC in October 2015 for review and use as part of their internal performance improvement process. The State MSHIP Domain scores for the Adult MHSIP, Youth Family, and Youth Services Surveys will also be presented to the MI PI Committee at the November 2015 meeting for their review and recommendations as applicable.

2014 MHSIP Survey Process Update

- Results from the 2014 surveys were distributed to the community providers in November 2014. Each CMHC received data containing:
  - The number of positive responses to each question on all surveys
  - A breakout by question of the 7 domains (Adult MHSIP, YSS, & YSS-F) with comparisons to the regional, state and US average.
  - A statewide regional comparison report on the Adult MHSIP
- The Statewide Regional Comparison report on the Adult MHSIP was presented at the February 2015 PI Committee.

Peer Review Child & Adolescent 2014

The Office of Performance Improvement, Division of Mental Health and Substance Abuse Services, coordinated and participated in an independent peer review of the AltaPointe Health Systems Transitional Age Services Program on September 19, 2014. AltaPointe Health Systems served as the host site while Jefferson, Blount, and St. Clair Mental Health Authority (JBS), Montgomery Area Mental Health Authority (MAMHA), and Cherokee, Etowah, Dekalb Mental Health Center (CED) served as reviewers. The purpose of peer review is to share ideas, best practices, and other innovative treatment strategies so that other centers may take this information back to their program and improve consumer services. Other areas covered during the Peer Review included:

- Goals of the Program
- Eligibility Criteria for the Program
- Admission Criteria for the Program
- Penetration Rate
- Assessment
- Treatment Planning
- Training
- Supervision
- Process Monitoring
- Outcomes Monitoring
- Quality Assurance
- Client Choice
- Barriers
- Things that have helped make the program a success

Peer Review Adult 2014

The Office of Performance Improvement, Division of Mental Health and Substance Abuse Services, coordinated and participated in an independent peer review of the Chilton Shelby Mental Health Center Evidence-Based Practice of Supportive Housing on July 31, 2014. Chilton Shelby MHC served as the host site while Jefferson, Blount, and St. Clair Mental Health Authority (JBS) and Montgomery Area Mental Health Authority (MAMHA) served as reviewers. The purpose of peer review is to share ideas, best practices, and other innovative treatment strategies so that other centers may take this information back to their program and improve consumer services. Other areas covered during the Peer Review included:

- Goals of the Program
- Eligibility Criteria for the Program
- Admission Criteria for the Program
- Penetration Rate
- Assessment
- Treatment Planning
- Training
- Supervision
- Process Monitoring
- Outcomes Monitoring
- Quality Assurance
- Client Choice
- Barriers
- Things that have helped make the program a success

Peer Review Child & Adolescent 2015

The 2015 Child & Adolescent Peer Review will be held on Tuesday, September 15, 2015, at the Jefferson, Blount, St. Clair Mental Health Authority (JBS) Training Center, located at 1950-B Crestwood Boulevard, Irondale, Alabama 35210. The focus of the peer review is the use of a Certified Youth Peer Specialist in a residential treatment setting. As part of the review, participants will take a field trip to Hill Crest Hospital in Birmingham, Alabama to meet with hospital

staff and will also be able to interview several consumers who have had the opportunity to receive services in a treatment setting that utilizes a Youth Peer Support team.

Peer Review Adult 2015

The 2015 Adult Services Peer Review will be held on Wednesday, August 26, 2015, at the Jefferson, Blount, St. Clair Mental Health Authority (JBS) Training Center located at 1950-B, Crestwood Boulevard, Irondale, Alabama 35210. The focus of the peer review will be the JBS Mental Health Urgent Care Clinic in Birmingham, Alabama. Participants will tour the clinic as part of the review.

Inpatient Services

The following outlines the key Inpatient performance improvement initiatives for the Committee this year:

- Restructure Mock Survey Process-Implemented new mock survey process for the state psychiatric hospitals. Instead of a one-time all-inclusive process there are three mocks with focus on clinical issues, administrative issues and environmental/life safety issues.
- Closure of North Alabama Regional Hospital-Provided tracking of monitoring process for consumers who were discharged during the closure process. Monitoring process including ADMH, Advocacy and ADAP. Consumers monitored for well-being and satisfaction up to 180 days post discharge from NARH.
- Redesigned the MHSA PI report to the Governing Body
- Worked with Infection Control Subcommittee to document and measure employee participation in taking the influenza vaccine
- New HBIPS (ORYX core measures) **IMM-2, TOB-1, TOB-2, and TOB-2a** went into effect beginning with January 2015 discharges. However, the IMM-2 data collection does not begin until the 2015 flu season (October 1, 2015 –March 31, 2015).

IMM 2 – Influenza Immunization

Measure Definition: This prevention measure addresses acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated.

TOB 1 – Tobacco Use Screening

Measure Definition: Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30days.

TOB 2 – Tobacco Use Treatment Provided or Offered

Measure Definition: Hospitalized patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the first three days after admission.

TOB 2a – Tobacco Use Treatment

Measure Definition: Hospitalized patients who received counseling AND medication as well as those who received counseling and had reason for not receiving the medication during the first three days after admission.

Section IV: Environmental Factors and Plan: 11. Trauma

Each ADMH-certified Mental Health Service Provider is required to develop Policies and Procedures that address the requirements codified in the ADMH Administrative Code. The "Consumer Records" Section of the Alabama ADMH Administrative Code (updated 9/30/10) requires trauma history to be obtained from every consumer and recorded in the consumer's clinical record so that it can be considered during treatment planning. (ADMH Code 580-2-9-.06 (9)(a.)17.(b.)10.). Also, in the "Child and Adolescent Restraint and Seclusion" Section of the Code (which applies only to Day and Residential Treatment programs that are certified to employ the use of seclusion or restraint techniques) clinical staff is required to perform an initial assessment at the time of admission or intake which includes information about "Preexisting medical conditions or any physical disabilities and limitations that would place the consumer at greater risk during restraint or seclusion, including developmental age and history, psychiatric condition, and trauma history." This Section also requires that this information be recorded in the consumer record. (ADMH Code 580-2-9-.23 (14)(b.) and –.23 (23)(d)3.) These requirements are codified with the belief that consideration of this information will help minimize the use of restraint and seclusion, and also to minimize the danger of re-traumatizing a consumer during the exercise of restraint or seclusion when it cannot be avoided.

Many ADMH policies are rooted in the provision of person-centered and individualized treatment planning as prescribed in the ADMH Administrative Code. This requirement is expressed succinctly in section 580-2-9-.08(3) entitled "General Clinical Practice," which states, "Services must be individualized, well-planned, based on a comprehensive mental health evaluation and assessment of needed treatment and support, and should include treatment designed to enhance the consumer's abilities to recover and function in society as normally as possible," and also, "Each program shall provide individualized mental health care and treatment that is designed to promote Recovery and Resiliency and that represents person-centered treatment planning process." This philosophy of care pervades all areas of service provision by ADMH certified providers. Consumers who present with histories of trauma that impact their presenting mental health conditions should be provided the best interventions available to accommodate their mental health treatment needs, including trauma-focused therapeutic interventions wherever appropriate. As a true trauma-focused system of care has not yet been achieved across the state, the types of trauma-focused therapy interventions will vary by provider agency and by individual clinician. ADMH does not have policies beyond what is provided for in the Administrative Code that require providers to deliver a specific trauma-focused intervention. Trauma-focused care is an important and growing field in mental health care, and a variety of training events and workshops have been conducted. Each provider is responsible to conduct or promote training opportunities for their clinicians and other treatment staff that will help them to develop professionally and to provide the best, most effective treatment possible for consumers of mental health services, including training and development in the area of trauma focused care.

Section IV: Environmental Factors and Plan: 12. Criminal and Juvenile Justice

- 1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

Not at the present time. Governor Robert Bentley announced in November of 2012 that Alabama would not participate in Medicaid expansion because of funding and thus far this decision has not changed.

- 2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

The establishment of a secure medical facility by the Alabama Department of Mental Health (ADMH) was authorized by the Alabama Legislature in 1975. Taylor Hardin Secure Medical Facility commenced operation in November, 1981. Taylor Hardin is the state's only forensic hospital and the facility provides inpatient evaluation and treatment services throughout the judicial process. Regional evaluation programs under Taylor Hardin's supervision also provide forensic evaluation services within the community. Pre-trial evaluations and treatment services are provided for males committed by the circuit courts of all sixty-seven (67) counties within the State of Alabama and are provided from the time of arrest through trial and sentencing. Female defendants receive inpatient evaluation and treatment services at Bryce Hospital.

Rule 11. Incompetentcy and mental examinations, of the Alabama Rules of Criminal Procedure, provides for the evaluation of a defendants mental competence to stand trial or to be sentenced if because of mental incompetence, he or she lacks the present ability to consult with counsel with a reasonable degree of rational comprehension or is unable to understand the nature of the proceedings. Once evidence exists to doubt the defendant's competence, the procedures for ordering a mental examination through the circuit court are implemented and the court orders are received by the Community Court Liaison at Taylor Hardin and dependent upon the order, evaluations are scheduled through the community regional examiners or defendants are admitted to Taylor Hardin or Bryce for inpatient evaluation. If a not guilty by reason of mental disease or defect defense is raised by the defendant, then the court on its own motion may order, or the defendant, the defendant's attorney, or the district attorney may move for an examination into the defendant's mental condition at the time of the offense. Orders for MSO evaluations are completed routinely on an outpatient basis by the community regional examiners or on an inpatient basis depending upon the court order. Evaluations of an individual's mental competence to waive Miranda and competence to participate in the sentencing phase are also completed as requested by the court.

- 3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

The Alabama Department of Mental Health (ADMH) has for years collaborated with the Department of Corrections (DOC) for the provision of treatment for individuals with mental health disorders who are serving sentences within the DOC. Through the probate commitment

process, inmates may be committed to ADMH for treatment to stabilize their condition and then returned to DOC for continued serving of the sentence. Individual who are approaching the end of their sentence, and who have mental health disorders, and are determined to be in need of continued treatment upon release from prison can be probate committed to ADMH for inpatient treatment at the time their sentence expires. Review of the data for these type commitments over the last 7 years has shown that many of these individuals are treated and discharged to community placements after relatively brief periods of inpatient treatment. This data has led to further discussion between the two agencies to focus on planning and developing procedures where by mentally ill inmates can be triaged prior to the End of Sentence (EOS) date and linkages to community providers established for after-care and assistance with transition into the community. It is expected that this will reduce or eliminate the need for EOS commitments to state hospitals.

A Forensic Workgroup began meeting in February 2013 to evaluate forensic services throughout the hospital and community continuum and make recommendations for improvement. Formal recommendations have not yet been finalized for submission to the Commissioner, however throughout the time the Workgroup has been meeting, there have already been implemented changes for improvement of our current system. One area of discussion has been the beneficial efforts of one counties Mental Health Court and the potential for these courts to have a positive impact on diverting individuals with mental health and substance abuse disorders who have minor/misdemeanor charges, from prosecution, thus reducing the numbers of individuals who have to assert a mental state defense and be found Not Guilty by Reason of Insanity (NGI) or those who are found guilty and sentenced to the criminal justice system. Concerns with the lack of consistency in how the mental health courts operate across the state and the lack of funding for these courts was discussed and recommendations for gathering data, collaborating with the Administrative Office of Courts, and exploring funding options will be submitted to the Commissioner. Also, the process of ensuring that individuals who are released from an ADMH commitment under a Condition Release is having the appropriate follow-up care and response to the court systems. Through the assessment of the Conditional Release process, ADMH initiated the use of an ADMH Conditional Release Community Monitoring Form that mental health providers are required to complete prior to filing a petition for Revocation of a Conditional Release. This is in an attempt to improve care coordination as to confirm that all community resources have been exhausted. Through the monitoring of the data with this new process, ADMH is hopeful that consumers can be diverted to more appropriate community based care setting. Another area of focus for the Workgroup is the revision of the Notice of Proposal for Conditional Release Order that will require community provides to send notice to ADMH of petitions for Revocations, as well of supporting documentation. The Workgroup is exploring the use of Self-Limiting orders for Conditional Releases, which would legally indicate that the Conditional Release would remain in effect for a period of one year, after which the conditions of the Defendant's release will terminate and the individual would be Unconditionally released from ADMH custody.

During this year's legislative session, the Alabama Legislature approved a bill intended to reduce overcrowding in Alabama prisons. The bill was crafted by the Alabama Prison Reform Task Force with the help of The Council of State Governments. At present, DOC has approximately 24,000 inmates in facilities designed for approximately 13,000. The bill would reduce penalties

for some nonviolent property and drug crimes, create a new Class D felony designation for some nonviolent offenses, and place new emphasis on parole and supervision of offenders to divers some form prison and keep others from going back. However, the reality is that Alabama's prison system will take time and funds for true reform.

In regard to adolescents, ADMH has a long working relationship with AOC and DYS. As outlined in other areas of this application, in 1999, ADMH developed a position called the Juvenile Court Liaison JCL) and contracts with each of the community mental health centers to have at least one JCL per catchment area. The JCLs work directly with the courts as to divert kids with behavioral health issues into more appropriate treatment at the least restrictive setting. The JCL also assists the courts with ADMH commitments occur. The JCL will work directly with the court process, from beginning, through placement with ADMH, and through the release of the ADMH commitment. This is vital to guarantee that care coordination needed clinically and legally are met. The JCL also has the capability to work directly with DYS when an adolescent if found delinquent as to assist with transition back to the community upon release. Local providers have also made efforts to expand resources with their local community partners and there are areas in which dedicated staff provide care in detention centers and for DYS community providers. Also, ADMH, DHR, and DYR have partnered through the OUR Kids project which has expanded services to adolescents who are more complicated and are involved with dual agencies.

- 4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Per the State of Alabama DOC Administrative Regulation #700: The ADOC ensures that those in custody of ADOC have access to medical, dental, and mental health services and are housed in settings that can provide for their specific health care needs. It is the policy of the ADOC to ensure a continuity of care when an inmate is admitted into or released from the system. It is also the policy of ADOC to facilitate the coordination of efforts in the provision of mental health care between ADOC psychological services staff and contract mental health staff. Judges also have the ability to order substance use assessments and treatment. Individuals may enter the system through several avenues which may include probation, mental health courts, drug courts and other problem solving courts (e.g., juvenile, veterans, and family drug courts). Individuals are assessed for appropriate care either in the detention centers at the time of entry or in the community.

- Alabama Justice Ministries Network is a non-profit faith based organization that was founded in 2001 and works primarily with the Alabama State prison system. The goal of their mission is to provide services necessary to assist ex-offenders to best gain and retain employment opportunities. Services that are included are mentoring, educational and vocational training, life skills programming, housing and continued substance abuse treatment. They start their work with the offenders while they are still incarcerated.
- Aid to Inmate Mothers (AIM) that was founded in 1987 and works primarily with women at Tutwiler prison, Birmingham Work Release and the Montgomery Community Based Facility. The goals of AIM are to enrich the lives of both incarcerated mothers and their families through programs that provide education and support. Care doesn't just stop once the mothers are released from prison. AIM's Project Reconnect is an aftercare program

that helps them secure job and housing, and provides them with essential counseling. AIM also has transitional home for women who are leaving prison.

- As for youth, the Alabama Department of Youth Services (ADYS), they also ensure that those in custody have access to medical, dental, educational, mental health, and substance abuse services, as well as housed in setting that can provide for their specific health care needs. ADYS works bi-directionally with the community courts, educational systems, and other child serving agencies (child welfare, mental health, etc.) to divert unnecessary commitments and to coordinate efforts for effective transition for return to their community. Over the years, ADYS has set up systems to fund community diversion programs as to enrich community resources in the hopes of providing rehabilitation opportunities. One such example with ADMH is the partnership with OUR Kids.
- Due to the belief that too many SED youth were channeled through the juvenile justice system, ADMH developed a position called the Juvenile Court Liaison (JCL) and provided funding for this position to each of the contracted community mental health centers. The JCL works directly with the court system to assist with determining appropriate treatment and care and to assist with coordination of such services and with those care agencies involved.

- 5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?
  - ADMH participates in trainings with other state agencies such as AOC, DOC and DYS. There have been collaborative grants/projects that has allowed for trainings and conferences to assist in strengthening the efforts of effective care in regard to mental health and substance use/abuse issues that focus on the use of evidence-based/best practices.
  - In addition, trainings offered by ADMH are open to anyone interested in attending. The DOC has been sending professionals to those trainings as a way of improving the quality of care offered to the offenders.
  - ADMH also offers annual training on forensic mental health issues that is open to the public and provides forensic case manager training.
  - Law enforcement officials have been receiving training in mental health first aid as part of a grant opportunity.
  - In regard to adolescents, ADMH provides annual trainings to the Juvenile Court Liaisons, as well as requested trainings by the community juvenile court systems and DHR.
  - At the local level, the ADMH providers actively participate in such collaborative trainings as trainers and as participants.

Section IV: Environmental Factors and Plan: 13. State Parity Efforts

ADMH has experienced a reduction in the amount of funds received over the past 6-7 years, with Block Grant dollars, due to the redistribution of funds between states, as well as significant budget cuts with state dollars. Alabama is also initiating Medicaid Reform and it is currently unclear how this will impact ADMH's budget. For FY16, the state of Alabama does not currently have an approved budget and a second Special Session will be needed to achieve this prior to October 1, 2015, when Alabama's fiscal year for FY16 begins. The final version of the General Fund Budget that was pending at the end of the first Special Session proposed to cut the ADMH by 5% ($5.3M).

At this time, ADMH is implementing its own Reform efforts to ensure that the consumers we are mandated/required to serve can be achieved. ADMH can explore the most appropriate process needed to move forward with the development of a community plan to educate and raise awareness about parity during this process. But, the exact approach needs to be developed with key stakeholders.

ADMH has had previous success in coordinating with entities across the public and private sector to address emerging issues that affect individuals with MH/SUD. It will endeavor to do the same with parity. As it is determined how to most effectively develop a communication's plan, the ADMH will pursue collaboration with organizations experienced in parity education. ADMH routinely uses its existing relationships with a variety of public and private agencies, as well as its role on various planning bodies, to relay information about the benefits of mental health services and/or resources. There is an assumption that the Federally Facilitated Exchange will be doing the majority of the outreach.

Section IV: Environmental Factors and Plan: 14. Medication Assisted Treatment

Not Applicable for MI Block Grant. Please refer to the SA Block Grant Application for this section.

Section IV: Environmental Factors and Plan: 15. Crisis Services

It is our understanding that this section is more for informational purposes and not a requirement to complete.

As indicated throughout most all the sections of this application, it should be apparent that ADMH, its partners, and the system as a whole focus on a system of care that includes all levels of care, treatment, recovery, and support. A vital element at all levels is crises access, treatment, and follow-up. Care coordination is crucial to ensure all aspects are linked for coordinated continuum of treatments, services, and supports. Alabama currently participates is some level of crisis prevention and early intervention, crisis intervention/stabilization, and post crisis intervention/support services identified above and this is documented throughout the application. ADMH is dedicated to provide and/or participate with its partners as to identify and effectively respond to, prevent, manage and assist individuals, families, and communities recover from behavioral health crises.

Section IV: Environmental Factors and Plan: 16. Recovery

Within ADMH, consumers and their families play a crucial role in policy development, system transformation, and program implementation within every level of the service delivery network. For years, ADMH has valued consumer voice and promoted inclusion that was meaningful. Through strong alliances with the consumer and family advocate networks, ADMH has been able to drive our system of care in the direction that not only sees our consumers and their families as recipients of services but values them as vital partners at the table who serve as experts in this process.

The ADMH Office of Consumer and Ex-Patient Relations (OCER)

Over the years, the ADMH Mental Illness Division has primarily focused on designing a system of care that emphasizes a rich array of community services to complement the state hospital system of care. Much of the guiding principles were based on standards outlined in the Wyatt lawsuit. This lawsuit led to sweeping reforms in mental health systems in the state and ultimately across the nation. Developing a continuum of care within the community was the priority as to increase opportunities for consumers to live in the community with appropriate services that would minimize the need for re-institutionalization. Through this process, ADMH became increasingly aware of the value and need of consumer voice to guide the process. In 1990, the Alabama Office of Consumer Ex-Patient Relations (OCER), more commonly referenced as the Office of Consumer Relations (OCR), was established. It was the FIRST office of its kind in the nation. The purpose of OCER is to infuse the consumer perspective into the decision-making process and management of the Mental Illness Division. The director is a member of the executive management team of ADMH and directly reports to the Associate Commissioner. A primary strength of OCER is the ability to encourage recovery and hope among Alabama citizens with mental illness and their families. Additionally, the office promotes respect toward individuals with mental illness and works closely with consumer operated programs, advocacy and self-help organizations around the state.

OCER brings the mental illness experience, and its related treatment experiences, into the planning, policy making, and operations of the Division of Mental Illness Services.

The Office has three major functions:

(1) To advocate and provide consumer insight to the senior management teams of the Division of Mental Illness Services and other agencies;

(2) To promote, provide technical assistance and consultation in the establishment and funding of consumer self-help networks, peer operated services, including the Certified Peer Specialist/ Peer Bridgers, support/self-help groups, and consumer run drop-in centers;

(3) To promote recovery from mental illness.

(4) Coordinates the Alabama Certified Peer Specialist Training(s) Program.

The **Alabama Directions Council** serves as the advisory board of the Office of Consumer Relations. Its composition includes the presidents of local support groups and drop-in centers around the state, as well the Alabama Peer Specialist Association (APSA), Wings across Alabama (Wings), and the Alabama Minority Consumer Council (AMCC). The Council meets regularly to discuss important issues and to make collective decisions about the direction of the consumer movement. The Directions Council also plays a major role in planning the annual Alabama Recovery (formerly The Alabama Recovery Conference) and the funding of local consumer run support groups. The OCER newsletter, LISTEN, has a target audience of consumers around the state and contains information on consumer issues, activities and consumer success stories. LISTEN has a circulation of 3,000.

The Directions Council membership organizations created the first official consumer statement on recovery articulated in the 2007 statewide publication Consumer Driven Recovery Focused Mental Health System: A Consumer Perspective. This document outlines what a mental health system should look like and what the concepts, principles, key components, strategies, goals, and recommendations driving the system should be. Alabama consumers defined recovery as "an individual process in which a person with mental illness reclaims a sense of who they are in mind, body, and spirit." This definition and the specifics of the publication are in keeping with SAMHSA's working definition of recovery: "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential". This document has proven an invaluable guide, leading the planning and development of mental health services and supports to promote and sustain the stated wishes and desires of "a job, a home of their own, a social life, and to contribute to society" voiced by Alabama consumers. (See attached 2007 White Paper)

The Alabama Institute for Recovery (formerly The Alabama Recovery Conference

This annual training event is organized by the OCER and occurs in the largest venue available in the state. Approximately 800 participants attend each year with more than 600 attendees awarded scholarships that would not be able to attend otherwise. This year marked the 23rd year this conference has been held. Activities during the conference include educational sessions and workshops, along with the presentation of the annual RESPECT awards, the annual Talent Show, a candlelight vigil, a watermelon social, and a dance. This three day conference, not only offers educational and inspirational tracks, but promotes opportunities for true peer camaraderie and empowerment. The Associate Commissioner of Mental Health Substance Abuse Services, senior executive staff, and facility directors participated in the conference to assist consumers and make their stay as pleasant as possible. Medical staff from state psychiatric facilities and community mental health centers volunteer every year to be part of the Crisis Response Team. Health Screenings were offered to consumers in attendance. These screenings were initiated in 2006 and conducted every year except for 2012. (see attached 2015 AIR Conference Brochure)

Certified Peer Support Specialists

ADMH has long valued the power of peers to support fellow consumers and promote recovery. ADMH first established the position of peer support specialist in 1994 at Greil Hospital and later expanded the program to all state facilities. In 2008, the Mental Illness Coordinating Subcommittee approved allocation of $1M in FY08 to support the equivalent of 25 full-time Peer Support positions, one to be employed at each contracted community mental health provider. Certification training based on the Georgia model was established with guidance from the National Technical Assistance Center of the National Association of State Mental Health Directors. Three trainings were initially conducted using the Depression and Bipolar Support Alliance and the Appalachian Consulting Group as trainers. When reduced budget allocations forced cuts in FY09, twelve mental health centers lost the funding for any vacant Peer Support positions. However, 2011 held more promise when grant funds allowed for the development of in-state certification training and thereby, increase the pool of certified peer specialist. With assistance from Appalachian Consulting Group, the Office Consumer Ex-Patient Relations (OCER) utilized a Train the Trainer model to create the capability to offer certification training provided by Alabama peer trainers thus reducing the dependence and cost of out of state trainers. The first two in-state

training occurred in August and -October 2012. A second Train the Trainer training was held in December 2014. OCER also coordinated two trainings for supervisors of Certified Peer Specialists. This was made possible through an approved SAMHSA TA Tracker request and OCER was able to utilize the expertise of consultants with the Appalachian Consulting group from Georgia.

Additionally, the need for specialty peer support services has provided opportunities to expand the use of peers in mental health settings. In light of the report that individuals with mental illness die 25 years younger than the general population, ADMH and a Birmingham provider participated in a NASMHPD funded pilot project in 2009 utilizing certified peer specialist to assist consumers in improving their overall physical health. In 2010, through the hospital downsizing project, the use of Peer Bridgers was initiated. Peer Bridgers concentrate efforts in assisting consumers in making the transition from the hospital to successful living in the community.

With the closures of the two state hospitals in 2012 (Greil and Searcy) and movement of treatment more focused in the community, this allowed for the expansion of the use of Certified Peer Specialists (CPS) within the continuum of care and CPS were hired in different settings such as within group home settings and on crisis mobile teams. This was further expanded with the repurposing projects targeting NARH and Bryce State Hospital.

In March 2014, ADMH partnered with a community mental health center and an ADMH certified private C&A psychiatric residential treatment facility to introduce the use of a Youth Certified Peer Specialist when working with some of the most complex female adolescents being served in such a setting in the state of Alabama. The community mental health provider employees the Youth Certified Peer Specialist. This pilot demonstration is being monitored closely by ADMH through the Child and Adolescent Task Force. For the FY15 SAMHSA MH Block Grant Peer Review, this project will be the host for the C&A peer review as to move toward expansion into other residential programs, as well as the ADMH Unit at UAB where the adolescents committed to ADMH for psychiatric treatment are served. The Block Grant is being utilized to support the development of this demonstration project.

Currently there are 54 certified peer specialists/peer Bridgers employed at community mental health centers, one located at a state hospital, 18 others serving in mental health related positions, and 10 employed by mental health consumer and family organizations.

Consumer-operated services

Consumer-operated services provide alternatives for mental health consumers living in the community. Unfortunately, there is very little expansion of operations that would allow for the opportunity of choice for the consumers we serve. Consumer-driven recovery, such as consumer run drop-in centers and support groups, are seen as essential elements of the continuum of care, but these services are not covered in the Department's contract with community mental health centers. The Block Grant is used to support the development of consumer-operated services as well as the annual consumer conference. There are five operational drop-in centers serving on average an approximate total of 114 consumers on any given day. Within the state, there are twenty-four support groups, 4 statewide consumer organizations, and 10 NAMI connection groups.

Office of Deaf Services (ODS)

Among the one in five Alabamians who will need mental health services in their lifetime are more than 40,000 people who are deaf or hard of hearing. ADMH has established an Office of Deaf Services (ODS) to serve deaf and hard-of-hearing Alabamians better. ADMH is committed to ensuring that their peers will design programs for deaf and hard-of-hearing persons to ensure services are linguistically accessible and culturally affirmative, giving the consumer every opportunity to make progress to recovery. The ODS staff includes a director, statewide services coordinator, a statewide mental health interpreter coordinator, statewide and regional clinical staff, and regional communication access team members. ODS also provide significant communication and clinical support to Bryce, where deaf people needing inpatient care are served. ADMH has developed specific standards of care for people with hearing loss that includes, among other things, specific requirements for measurable fluency in American Sign Language for certified community programs which work with deaf consumers. Also, through contracts with ADMH, the contracted providers have access to language interpreters regardless of language and those services to assist with language needs as needed in services and care.

ADMH has developed specific standards of care for people with hearing loss that includes, among other things, specific requirements for measurable fluency in American Sign Language for certified community programs which work with deaf consumers. In FY14, ADMH and providers began capturing data on the client's primary language to facilitate meeting linguistic needs of our client populations. This readily allows ADMH to track consumers who are deaf or hard of hearing and target resources in an efficient manner. This allows ADMH to pinpoint and define the consumer characteristics of the 1,787 hard of hearing people and 200 deaf people that received services from ADMH in FY14.

In FY14, ODS staff provided community-based services directly to 1,154 consumers and 6,025 consumer contacts throughout the year. Technical assistance and consultation was provided to 3,668 people and programs. 8,272.75 hours of interpreter services were provided for deaf consumers. Of this, 6,889.5 hours were provided by staff interpreters. This was in spite of having an interpreter vacancy the entire year.

However, a shining gem of the Office of Deaf Services training is the nationally acclaimed Mental Health Interpreter Institute, which is annual 40-hour training for interpreters working with mentally ill deaf consumers. This training, which is funded by the block grant, draws participants from all over Alabama and around the country. A website, www.mhit.org, has been set up to help provide interested people information about the project. For FY14, this annual Institute, with attendance, was "sold out" months before the opening session. Altogether, 85 individuals from 28 different states and 2 foreign countries were on hand. The total attendance with all staff, volunteers and participants was 115. Since the first Interpreter Institute, 720 different people have been trained, an average of 65 new people every year. (See attached ODS FY14 Annual Report).

Consumer Advocacy Services

Rights Protection and Advocacy Services for persons in state facilities have long been a top priority for the ADMH. In October 1997, the ADMH greatly enhanced this effort, when the Internal Rights Protection and Advocacy Program officially expanded its role, and began providing services to persons being served in community programs that were under contract with ADMH or programs

which were certified by the ADMH. Services provided include: information and referral services; complaint intake, investigation and resolution services; participation in certification reviews of new community programs, as well as programs with problematic rights-related issues, to ensure standard compliance; unannounced monitoring of community residential and program areas; and rights education and training.

With a staff of 26 certified advocates working out of five service area offices across the state and in the central administrative offices, the internal advocacy program provides a non-adversarial system of rights protection and advocacy that focuses on rights awareness and prevention of rights violations. A number of the advocates are family members or consumers. Community advocates conduct random or for cause unannounced visits to community residential and day program providers, now including foster care facilities. The Office of Advocacy Services has a toll-free telephone line to address rights-related issues and also is notified of all community Serious Special Incidents.

The Office of Advocacy Services meets at least quarterly with the Advocacy Advisory Board. It is represented on the Mental Illness Coordinating Subcommittee, the MI Community Standards Committee, and other MI committees as needed. Community and facility advocacy services are integral to the quality of services and ADMH's commitment to respect and enforce consumer rights.

Wings Across Alabama

In 2003, consumers across Alabama were vocalizing the need to re-establish a consumer organization. ADMH and the Alabama Disabilities Advocacy Program (ADAP) coordinated grass roots meetings that became known as "Rekindling the Spirit". The mission was to unite consumers of mental health services statewide. In February 2004, ADMH announced an RFP to provide state-wide consumer advocacy activities and develop a state-wide consumer organization. This RFP was awarded in April 2004 and Wings Across Alabama was established. Wings is a non-profit organization for consumers of mental health services with a dedication to making positive change in the lives of consumers through education, advocacy, training, services, and technical assistance as well as through building a strong network of consumers across Alabama with the recognition that inclusion, peer support, true community involvement and participation, self-empowerment, and quality mental health services are KEY ingredients to recovery. Wings strive to improve and reform the community mental health system so consumers of mental health services can become effective advocates for themselves and others. The organization is run by consumers of mental health services for consumers of mental health services.

National Alliance of Mental Illness – Alabama Chapter (NAMI)

NAMI Alabama is an organization comprised of local support and advocacy groups throughout the state dedicated to improving the quality of life for persons with a mental illness in Alabama. The number of such groups is growing rapidly as families become more determined to improve treatment and care for Alabamians diagnosed with a mental illness. Consumers and family members/friends affected by serious mental illness, their treatment, partners, and their supporters/allies united to advocate for a cure for severe disorders of the brain and to improve the quality of life of persons affected by serious mental illness by providing

1. Information, support, and a sense of belonging to persons with serious mental illness and their families;
2. Advocacy for nondiscriminatory and equitable federal, state, and corporate policies;
3. Research into the causes, symptoms, and treatments for severe brain disorders; and
4. Education to eliminate the pervasive stigma toward persons affected by serious mental illness.

Alabama Family Ties (AFT):
For many years, no unified statewide presence existed to represent and advocate specifically for children and adolescents with a serious emotional disturbance and their families. While many of the existing groups were active participants on mental health related statewide planning committees, a need was very evident to foster the development of a collective representation that could participate on behalf of children with a serious emotional disturbance and their families across all agencies (e.g. juvenile justice, child welfare, education, health care). A need existed, therefore, for a coalition of families and various advocacy groups to facilitate collaboration among families, advocates, and other child-centered coalitions and organizations. Funded in October 1998, a grant from CMHS for a *Statewide Family Network* resulted in the creation of Alabama Family Ties (AFT), a coalition of parents, family members, and existing groups and organizations. In addition to the planning involvement, the grant fostered skill development of AFT in the areas of leadership and advocacy, as well as business principles and practices. The coalition has designed a Strategic Plan based upon the needs of the children and their families with the outcome of improved visibility and enhanced awareness of issues affecting children with a serious emotional disturbance and their families. A board was created as per the Articles of Incorporation and is composed primarily of family members. Alabama Family Ties fills a distinct weakness in the system development structure: the absence of an organized independent family voice that is consistently present and involved. It is critical that families have a voice when discussions are held and decisions are made that individually and collectively impact their children and their families. Alabama Family Ties has been that voice and the catalyst for a chorus of voices.

Alabama Youth M.O.V.E. (AYM):
(AYM) is a youth-led organization established in Alabama in FY11, which is devoted to improving services and systems that support positive youth growth and development through uniting the voices of individuals who have been served by various systems including mental health, education and juvenile justice. AYM works closely with Alabama Family Ties and other advocacy groups, and participates at the state level with a presence on the MI Child and Adolescent Task Force and the MI Planning Council. AYM is actively seeking to involve more youth in the advocacy process and takes an active role in events such as the annual state-wide Children's Mental Health Awareness Week.

Wings, NAMI Alabama, Alabama Family Ties and Alabama Youth MOVE are strong advocates and primary stakeholders at the local and state levels. These organizations are intimately involved in the planning for mental health services provided to adults and children/adolescents in Alabama and have representation on ADMH's Management Steering Committee, the Mental Illness Coordinating Committee, and the Child and Adolescent Services Taskforce, as well as the Mental Illness Planning Council. ADMH has a vibrant Planning Council that, not only reviews and monitors the Mental Health Services Block Grant, but is also active in advocating for consumers

and providing leadership in program development. The bylaws spell out the purpose of the Planning Council. Consumers and family members hold majority membership on the Council. Either a consumer or a family member has chaired the Mental Illness Planning Council for the past several years.

The Governing Body of the MI facilities and the MI Facilities Directors Committee also have consumer and family member representation. Each group formed by the Department to tackle specific problems and issues has consumer and family member representation, including the Acute Care Task Force, the four regional planning groups, the Evidence-based Practices Workgroup, the System Reconfiguration Task Force, the Financing Strategies Workgroup, and the Medicaid Managed Care Workgroup. Additionally, consumer and family involvement is guaranteed through inclusion in the *Alabama Administrative Code*, which has the force and effect of law. Consumers and family members are also involved in resource allocation and service evaluation at the local community mental health center level.

Person-centered treatment planning has been adopted as the philosophy for ADMH through which consumers are assisted in articulating their vision and hope for how their lives will be changed for the better. Person-centered treatment planning training sessions have ongoing for several years in state facilities and with community mental health providers. A training manual has been developed for use by mental health professionals. Community mental health providers are expected to provide ongoing training on person-centered treatment planning and consumer directed services. In 2009, refresher training sessions were provided in four locations across the state related to the focus on improving recovery and resiliency capability of the system. Alabama's Administrative Code promotes the use of person centered treatment planning throughout.

Alabama currently has no formal policy on participant-directed services. Within ADMH, the Mental Illness Division has relied on a traditional community mental health center system of care. This has provided limited choices to the community providers of what services are offered. However, within the community mental health system at a local level, individuals have choice to what services they will accept, therapist within that system to provide the service, and individualized treatment planning. The efforts of ADMH have been to develop and enhance a continuum of care for both adults and children/adolescents that lends itself to a flexible array of services that are focused on meeting as a first priority the needs of people with a serious and persistent mental illness, particularly those who have been in a state psychiatric hospital. However, this is within the community mental health center itself and to develop a seamless system of care from hospital to community. All services are designed to be provided from a person-centered treatment planning perspective driven by family and consumer needs. Consumers receive not only high quality treatment services, but receive the necessary supports to achieve the highest degree possible of independent living in safe and decent housing, to be employed, to receive necessary medical care in a coordinated manner, and to engage in social interaction with friends and family. The struggle with expanding the provider network is the balancing of care coordination and collaboration necessary to maintain consumer recovery and foster resiliency.

ADMH supports a model for assessment, service planning, and service delivery that is person-centered, strength based, consumer-driven, and family-focused. Efforts to move the system toward

this have occurred at several levels. To try and develop infrastructure and build capacity, ADMH has engaged in the following:

- Updated the ADMH Administrative Code for MI Program Standards that incorporates person centered and recovery mandates for care. Person-centered treatment planning is outlined. Addressing the specialized needs of consumers who are deaf or hard of hearing was integrated in every level. So that consumers and their families can be informed of the quality of care of the provider, ADMH implemented having certification scores being posted on the ADMH website as a "report card".
- A regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. During FY09, there were numerous participants in the regional planning process including consumers, family members, Probate Judges, public community providers, state hospitals, and local private providers. In FY09, the planning process was expanded to separate local planning for adults from local planning for children and adolescents. This decision was based on feedback from the previous years of planning with the intent to improve the voice of children and adolescents and their families throughout the planning process. A series of local stakeholder planning meetings occurred in late summer and fall 2009. This provided an avenue to have local and regional input in determining unmet needs and critical gaps within the system at the community level. The local and regional planning process provides the foundation for the Department's annual budget request.
- ADMH implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool effective October 1, 2010 in order to address the concerns about the special individualized needs of child and adolescent consumers and their family members. This strengths-based assessment instrument has cultural subscales that guide service providers in assessing cultural strengths and helping families to select services that are culturally relevant to them. The CANS is linked directly to the treatment plan as to ensure the treatment is individualized, strength based, family-driven, and youth-guided. ADMH developed a statewide web-based application for the CANS as a means to gather data for NOMs and to measure performance and outcomes. It is anticipated that ADMH will implement such an instrument for the adult system.
- ADMH is working closely with Alabama Medicaid in efforts to expand coverage to those peer related services that would enhance a self-directed care system. ADMH has submitted language for consideration of a State Plan Amendment for the Rehab Option that would include Peer Support Services, Youth Peer Support Services, and Family Peer Support Services. Work continues on these efforts as other funding stream enhancements are being explored.

Special Projects

A portion of the Block Grant is reserved for Planning Council Special Projects. Historically, these funds have been allocated to a variety of educational and service components. These projects have supported transformational activities by providing education/training for family and consumer advocates, direct service staff, administrators, and other interested parties. In addition, the largest part of the Special Projects funding supports drop-in centers and other consumer operated services that directly address Recovery for consumer. Funding for drop-in centers and education programs offered directly by NAMI Alabama, Wings Across Alabama, Alabama Family Ties, and Mental Health America was continued as was funding for the annual Consumer Recovery Conference. The funded Special Projects (see attachment) continue to offer important training and educational

opportunities for families, consumers, and service providers. Administrative funds are used to pay the registration fee for Planning Council members to attend the Council of Community Mental Health Boards Annual Conference. This conference attracts several hundred mental health center and state agency staff and provides a variety of sessions of interest to Planning Council members

Housing

As previously detailed in Section 2-Step 1- under Housing, the Department is committed to offering services and supports to promote individuals' receipt of mental health treatment in the least restrictive, most integrated environment possible. Spurred by the Alabama Wyatt lawsuit and following Olmstead litigation, the state has successfully increased integration efforts through hospital downsizing and closures, as well as community service expansion initiatives. As noted earlier, compared to the FY09 baseline end of year average daily census, ADMH reduced the total statewide hospital census in FY12 by nearly 24%, in FY13 by 44%, and in FY14 by 50%. ADMH demonstrated nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015. The substantial portion of this success can be traced to the 2007/2008 Acute Care Project and the subsequent 2009/2010 Downsizing Project, for which systematic evaluation and analysis process was conducted in which of individuals residing on extended hospital wards or who had lengths of stays greater than 90 days. These evaluations were conducted by teams made up of advocates, clinical staff and peer specialists in which participants were surveyed as to their living arrangement preferences as well as service needs. This information, along with hospital treatment team assessments and recommendations, resulted in a structured plan for the development for services and housing to meet the unique needs of the target population.

Likewise, similar activities were conducted for target consumers residing in various group home and residential treatment models identified as having lengths of stays for a year or greater. Barriers to community integration were identified and served as a basis for planning housing, services, and supports necessary to address the unique requirements of this population. The specific services and program development for these projects and other integration efforts are detailed in Section 2-Step 1: Hospitalization-Downsizing Effort for Community Integration. Ongoing process of consumer needs assessment activities and community service expansion efforts have been components of subsequent Hospital Closure and Repurposing projects.

In an effort to monitor the appropriate utilization of residential treatment beds, the Department developed a web-based tool - Mental Illness Community Residential Placement System (MICRS). This system allows for Department level knowledge of residential utility, bed availability, specialty residential treatment programs (i.e. medical, forensic, duel-diagnosis), and lengths of stay for current occupants. ADMH has funding to support to use of Utilization Review Coordinators who are available to monitor MICRS on a regional basis and provide assistance to state psychiatric hospital staff and local mental health providers in locating the most integrated settings for individuals discharging from state psychiatric facilities as well as integrated residential treatment settings.

Wellness Promotion

In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, the Department has promoted health and wellness education

and activities. Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

A gain in momentum to address nicotine dependence among individuals with mental health disorder over the past decade has occurred within the state hospital settings. The state hospitals became tobacco-free on January 1, 2010. All state hospitals are currently smoke-free and interventions to assist consumers with this process have been implemented. For the contracted community mental health centers, there has been progress with initiation of individual endeavors to address smoking cessation, but ADMH has not implemented a state-wide process to address this issue.

For more detailed information in regard Wellness Promotion, please review Section I: Step I: Assess the Strengths and Needs of the Service System to Address the Specific Populations, as well as Section IV: Environmental Factors and Plan: 1. The Health Care System and Integration

Employment and Educational Needs

Employment opportunities for consumers are not well developed within the mental illness service milieu and are identified as a system weakness. Alabama Department of Mental Health and the Alabama Department of Rehabilitation Services have forged a longstanding collaboration in serving disabled populations. Concerted efforts of this collaboration have targeted individuals receiving mental health services. In FY14, the Alabama Department of Mental Health (ADMH) was awarded the Substance Abuse Mental Health Services Administration (SAMHSA) *Supported Employment: Transforming Lives* grant.

Also, in an effort to affect state policy, ADMH collaborated with other state agencies in an effort to pass an Employment First Bill. First introduced in the 2013 legislative session, the bill was well received but ended before the bill was adopted. Legislation was reintroduced in the 2014 legislative session, but failed to reach the floor for vote. Plans are underway to again introduce Employment First legislation in 2015 session. The Employment First Bill will affix "employment" as a legislatively affirmed priority. The passing of this bill will be viewed as a turning point in shaping state driven policy and funding mechanisms necessary to spark a transmutation in traditional services systems.

In regard to education, this is an identified area by ADMH for ensuring foundation building in a person's life to be able to achieve resiliency, independence, and recovery. For adults, case managers and clinicians from the mental health centers work with local educational institutions and Vocational Rehabilitation Services offices to refer consumers for education and employment

services. Consumers are provided basic educational services and pre-employment services in day treatment and residential programs. Outpatient consumers are referred to local GED classes and/or institutions of higher learning such as community colleges and universities based on the consumers' interests and abilities. Providers work with the Rehabilitation Services office to refer people for regular rehabilitation services as well as VR supported employment. For kids, ADMH appreciates a long-standing collaboration with the Alabama State Department of Education (ALSDE) stemming back to 1999. ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred school systems in the state. For numerous years, case managers, in-home intervention teams, and outpatient clinicians employed by the Community Mental Health Centers (CMHCs) have had frequent contact with the educational system on behalf of children with a serious emotional disturbance and their families. Since 1999, the two agencies have collaborated to blend funds and resources on projects that began with day treatment programs and now extended into an integrated, school based project, School-Based Mental Health (SBMH) Collaboration. The SBMH model improves access to appropriate mental health services by children who need them by placing a Master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. ADMH and ALSDE continue to jointly promote the School Based Mental Health Collaboration across the state, and have presented workshops on SMBH at ALSDE's MEGA Conference and Transition Conference in FY 12 and every year thereafter through FY15. SBMH Partner CMHCs and School Systems are currently gathering information to establish School Year 2014-2015 as the "baseline year for SBMH Data. This information will be used to analyze the effectiveness of SBMH over subsequent years.

For more detailed information in regard Employment and Education, please review Section I: Step I: Assess the Strengths and Needs of the Service System to Address the Specific Populations, as well as Section IV: Environmental Factors and Plan: 21. Support of State Partners.

Section IV: Environmental Factors and Plan: 17. Community Living and the Implementation of Olmstead

Since the United States Supreme Court decided the *Olmstead v. L.C.,* 119 S.Ct. 2176 (1999*)* decision regarding how persons with disabilities should be treated in the least restrictive and most integrated settings, the Alabama Department of Mental Health (ADMH) created a strategic plan that resulted in the settlement of the (at the time) thirty (30) year old *Wyatt* lawsuit. That agreement can be found as Appendix B to the court order approving the settlement and was ADMH's designated community integration plan. *See, Wyatt v. Sawyer,* 105 F.Supp.2d 1234 -1268 (M.D.Ala. 2000) (J. Thompson). ADMH substantially complied with the provisions of the settlement over a three-year period, resulting in the end of this landmark law suit that, among other things, was a precursor to the Americans with Disabilities Act that was later construed in the *Olmstead* case. *See, Wyatt v. Sawyer,* 219 F.R.D. 529 (M.D.Ala. 2004) (J. Thompson). *See also, Wyatt v. Rogers,* 985 F.Supp. 1356, 1432-33 & 1435 (M.D. Ala. 1997)(J. Thompson)(court rejected plaintiff's motion to add an ADA claim to the complaint as no additional relief was available under that statute beyond what already existed in the law of the case and the parties had already established the parameters of compliance therewith in an earlier consent decree).

During the implementation of the *Wyatt* settlement agreement, and since, ADMH has further planned and executed numerous major initiatives that effectuate the letter and spirit of *Olmstead.* For example, , the *Wyatt* settlement required a minimum of three hundred beds in extended-care psychiatric hospitals and three hundred people residing in developmental centers (intermediate care facilities for people with mental

retardation, i.e. ICF/MR) be closed and the individuals placed in community-based settings, respectively. Although ADMH declined to agree to the closure of any specific facility it operated, as it moved people with mental illness and intellectual disability to community-based settings, ADMH elected to close three developmental centers, two nursing homes (and the third and last one was closed thereafter in 2009), co-located one psychiatric hospital with another; eventually closing the relocated hospital.

ADMH's dedication towards enhancing community services and reducing the reliance on state psychiatric hospitals, has continued to reach far beyond the initial Wyatt mandates of extended-care census reduction. Since 1971, the census at Bryce alone dropped from over 5,000 patients to less than 400 in 2004. Through the dedicated efforts of state psychiatric hospitals and community partners, ADMH can boast nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to present (June 2015). This was accomplished through the closure of two state operated psychiatric facilities in 2012, one downsized and moved to a new location in 2014, and another closed in 2015. At present there are three state operated facilities serving acute care, extended care, geriatric, and forensic adult populations. ADMH contracts for inpatient services for the adolescent population. Through these operations, ADMH currently carries an inpatient capacity of 489 beds. A detailed description of hospital downsizing and community expansion activities are further described in Section II- Step 1 under Hospitalization (Downsizing effort for community integration) section of this grant application.

As part of the Wyatt settlement and to foster more housing opportunities for people with serious mental illnesses or intellectual disabilities, ADMH embarked upon a partnership with the Alabama Housing Finance Authority to prioritize portions of housing developments financed through a combination of low-income housing tax credits and the Home Investment Partnership Program. These plans were approved by HUD and netted up to fifteen percent (15%) of housing units developed through funding from these two programs for the years 2000 and 2001. Under this initiative, people with mental disabilities have a priority for occupancy up to the total of reserved units and when they vacate the premises that priority remains. Only, if after working with local mental health service providers and ADMH, housing managers cannot find a person with mental disabilities to occupy the premises, many other tenants occupy that small, integrated percentage of these units. ADMH Advocacy staff assist consumers with issues that may arise with the managers of these units (and others) with problems they may have with landlords, related to the tenants' illness or condition. Further information about ADMH Housing Initiatives can be found Section II – Step 1 under Residential Care, Housing Services, and Permanent Supportive Housing of this grant application. Parallel to the implementation of the *Wyatt* settlement agreement, ADMH also settled a law suit filed by deaf or hard of hearing consumers in a class action, alleging violations of the Americans with Disabilities Act, among other claims. *See,* Settlement Agreement, *Bailey v. Alabama Department of Mental Health and Mental Retardation.*

Upon the inception of the Home and Community Based Services Expansion Project, ADMH was a member of the Olmstead Planning Core Workgroup established by the lead agency Alabama Medicaid. The workgroup comprised of state agencies, consumer and advocacy groups, and other stakeholder representatives was charged with designing a three year strategic plan for expanding home and community-based services. Through the Wyatt settlement agreement, ADMH was required to implement a statewide community education plan, reduce institutional levels, and develop more community options. Several workgroups comprised of ADMH Administrators and hospital staff, consumer and family members, public and private mental health providers, and advocacy groups were established to form the Wyatt Implementation Plan. This Wyatt plan and Olmstead initiatives converged to create the roadmap to drive a reduction in the use of state psychiatric institutions and expand community service options. These plans included provisions for the expansion of recovery oriented supportive services such

as Peer Support Services and others. For a detailed description of support services specifically funded through hospital downsizing/community integration efforts, please refer to Section II- Step 1 under Hospitalization (Downsizing effort for community integration) section of this grant application.

Purposeful and inclusive planning supported the implementation of a census reduction, hospital downsizing, hospital closure, and hospital repurposing models in which the care of individuals housed within the States' extended care wards would be transferred to the community provider network along with the development of acute care capacity within the community. This resulted in a significant expansion of residential services many of which reflected the development of new "specialty", and small capacity (three bed) residential models to address the unique needs of extended care residents such as medical and forensic. It also resulted in the establishment of local designated mental health care facilities and local hospital partnerships. Expert training and consultation were provided through Olmstead funds and other funding sources to include deaf interpreter training, person centered discharge planning, and dual diagnosis services.

Funds continue to be dedicated for community integration and service expansion efforts though block grant dollars, general state funds, and other grant resources. Throughout the years, community integration and services expansion have been the focal point of the SAMHSA Block Grant goals and targets for mental health services. The MI Planning Council, which is the mandated body to approve the Mental Health Block Grant goals has assured this process and their guidance has steered the enhancements to this process to expand into peer directed care that is strength-based and person-centered. The MI Planning Council established guidelines for the submission and approval process for proposed uses of the stipend. Funding is dedicated to facilitate State's efforts to carry out the core values expressed under the Olmstead decision of promoting community integration for adults with serious mental illnesses and/or co-occurring substance use disorders and children with serious emotional disturbance.

For more detailed information on the State of Alabama Long Term Care Rebalancing Initiatives, please see attachment.

Section IV: Environmental Factors and Plan: 18. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

Within ADMH, the Mental Illness Division has relied upon a traditional community mental health center system of care. This has provided limited choices to the community providers of what services are offered. However, within the community mental health system at a local level, individuals have choice to what services they will accept, therapist within that system to provide the service, and contribute to individualized treatment planning. The efforts of ADMH have been to develop and enhance a continuum of care that lends itself to a flexible array of services that are focused on meeting the needs of children and adolescents with a serious emotional disturbance and their families. All services are designed to be provided from a person-centered treatment planning perspective driven by youth consumer and family needs. The importance of expanding the provider network is to achieve the balance of care coordination and collaboration necessary to maintain consumer recovery and foster resiliency. Although not established state-wide, ADMH does have experience in creating a modern system of care approach to delivering mental health services to children and adolescents with serious emotional disturbance and their families. In FY1997, ADMH received a SAMHSA Children's Mental Health Initiative System of Care (SOC) grant that covered the largest metropolitan area in

Alabama – Jefferson County. The Jefferson County Community Partnership (JCCP) project focused on developing a seamless system of care for children with a serious emotional disturbance and their families. JCCP incorporated two parent coordinators which are now the first parent support specialists in the children's mental health system in Alabama. All services were co-located with the system of care partners. The JCCP Advisory Council still exists today and is the driving force for the continued decision making process and expansion of care that holds true to the system of care values and concepts. In FY10, ADMH received a second SAMHSA SOC cooperative agreement that covers three rural counties in East Central Alabama. The East Central Children's Health Collaborative (ECCHCO) Project incorporates strategies around meeting the ethnic, cultural and linguistic needs of their children/adolescents they serve and their families. ECCHCO also has a full-time administrative parent/youth coordinator who addresses the diverse needs of child and adolescent consumers and their families. All services are co-located with the system of care partners. They incorporated a Family Advisory Council and a Youth Advisory Council, as well as youth and family representatives on the ECCHCO Advisory Council. The core values of system of care (community based, family-driven, youth-guided, culturally and linguistically competent) are infused at all levels within this system of care. Through the ADMH Child and Adolescent Task Force and within the ADMH planning process, both SOC sites are used as a laboratory of learning in the continued efforts to expand SOC core values throughout the state.

ADMH supports a model for assessment, service planning, and service delivery that is person-centered, strength based, consumer-driven, and family-focused. Efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, ADMH has engaged in the following:

- The regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. There have been numerous participants in the regional planning process including consumers, family members, judges, public community providers, state hospitals, and local private providers. The local and regional planning process provided the foundation for ADMH's annual budget request. In FY09, the planning process was expanded to include a separate planning function for children and adolescents. This decision was based on feedback from the previous years of planning and was implemented to improve the voice of children and adolescents and their families throughout the planning process. A series of over 90 adult/children and adolescent local stakeholder planning meetings occurred in late summer and fall 2009. This provided local and regional input in determining unmet needs and critical gaps within the system at the community level. The feedback from this process was utilized within the departmental planning process as a mechanism to introduce local community input and was instrumental in the identification of needs and gaps in service. During FY 2011, ADMH leadership worked jointly with the Mental Illness Coordinating Subcommittee and Management Steering Committee to make recommendations for goal and strategy improvements. This collaboration has resulted in thorough examination of planning targets that reflect the approval of stakeholder partners while balancing the realities of ADMH fiscal parameters and magnifying the benefits of the integration efforts made within the division. This process has continued through FY 2015.
- Planning for children and adolescent services is performed as a part of the overall Management Steering Committee process described above via a Child and Adolescent Services Task Force.

The Task Force is constituted from a representative group of stakeholders, including advocates and family members whose primary focus is children and adolescents. This body assesses the needs of the state, designs the conceptual framework, and prioritizes strategic growth of child and adolescent services for the ADMH Mental Illness Division.

- The ADMH Administrative Code for MI Program Standards was updated in FY10 to incorporate person centered and recovery mandates for care. Person-centered treatment planning is outlined. Addressing the specialized needs of consumers who are deaf or hard of hearing was integrated in every level. So that consumers and their families can be informed of the quality of care of the provider, ADMH moved toward having certification scores being posted on the ADMH website as a "report card".
- ADMH implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool effective October 1, 2010 in order to address concerns about the special individualized needs of child and adolescent consumers and their family members. This strengths-based assessment instrument has cultural subscales that guide service providers in assessing cultural strengths and helping families to select services that are culturally relevant to them. The CANS is linked directly to the treatment plan as to ensure the treatment is individualized, strength based, family-driven, and youth-guided. ADMH developed a statewide web-based application for the CANS as a means to gather data for NOMs and to measure performance and outcomes. All MI contracted providers have Child Adolescent staff trained and a CANS completed on all Child/Adolescent consumers as of April 1, 2011. In 2013/2014, ADMH moved into an enhancement process for the CANS certification/re-certification process and joined a national consortium to achieve this, The Praed Foundation. By January 2015, all the mental health providers contacted with ADMH were members of the Praed Foundation under the jurisdiction of Alabama. This allowed ADMH to enhance the timeliness of certification/re-certification and the technical guidance that enriches to process of utilizing the CANS as a multi-purpose tool.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

Person-centered treatment planning has been adopted as the philosophy for ADMH through which children and adolescents are assisted in articulating their vision and hope for how their lives will be changed for the better. Person-centered treatment planning training sessions have been ongoing for several years in state facilities and with community mental health providers. Community mental health providers are expected to provide ongoing training on person-centered treatment planning and consumer directed services with a focus on improving recovery and resiliency capability of the system. Alabama's Administrative Code promotes the use of individualized, person centered treatment planning throughout and codifies meaningful contribution by the child/adolescent and responsible caregivers in all aspects of treatment planning and implementation. The CANS is also an instrument designed to be utilized in the person-centered treatment planning process.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

ADMH has for many years partnered with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources,

to provide a comprehensive array of publicly funded services to children/adolescents through memoranda of understanding, intergovernmental service agreements or informal relationships. For specific information regarding collaborative efforts between ADMH and other state child-serving agencies, please see Section IV, Environmental Factors and Plan: 21. Support of State Partners.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

A number of different EBPs related to various aspects of mental health prevention, treatment and recovery are utilized by different Child/Adolescent service providers. Each EBP has its own training/certification process, which is managed by the agency implementing the practice. At this time, EBPs have not been established at a state-wide level. A promising current mental health provider implementation of an EBP is the establishment of the Coping Power program for children/adolescents and their families in an area of rural Alabama as part of the ECCHCO Project discussed above. A Patient Centered Outcome Research Institute grant proposal was submitted in August 2013 by Dr. John Lochman, creator of Coping Power, in collaboration with ADMH, but was not awarded.

ADMH has implemented a promising practice of School-Based Mental Health Collaboration in which much training and efforts of focus have been placed as to ensure a more preventive effort to integrate a seamless system of mental health care in educational settings. All of this is in an effort to provide treatment that is more holistic and in a way to build strength and resiliency for young people personally and with their educational successes. For specific information regarding collaborative efforts with SBMH, please see Section IV, Environmental Factors and Plan: 21. Support of State Partners.

ADMH is also in the process of implementation of First Episode Psychosis (FEP) which requires certain training elements in order to meet the fidelity of the model. For specific information regarding collaborative efforts with FEP, please see Section IV, Environmental Factors and Plan: 5. Evidence-Base Practices for Early Intervention (5 percent set-aside).

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders? "

The Child and Adolescent Needs and Strengths assessment tool described above (see question 1.) is linked directly to each consumer's treatment plan to ensure that treatment is individualized, strength based, family-driven, and youth-guided. ADMH developed a statewide web-based application for the CANS as a means to gather data for NOMs and to measure performance and outcomes. All MI contracted providers have Child/Adolescent staff trained to perform the CANS assessment, and a CANS is completed on all Child/Adolescent consumers during the Intake process and at least every six months afterward. Clinicians at the local level are able to access outcome information on their individual consumers over time and assess progress in a number of different functional areas. This information is explored and discussed in treatment planning sessions with the consumer and family members, and is used to help determine appropriate treatment goals and interventions during the course of treatment. At the ADMH level, the CANS database is designed to provide accessible NOM information and is available to help in gauging the effectiveness of programming for children and adolescents. For example, efforts are currently underway to use CANS data to produce outcome

information to help measure the effectiveness of the School-Based Mental Health project which is becoming established in many locations around the state.

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

ADMH has not developed a "liaison" position if you will, but all the community mental health providers work closely with the local educational settings and most, if not all, have a current local arrangement with their LEAs to assure identified children and adolescents are connected with available mental health services. The SBMH Collaboration Program does identify a liaison for this process, both with the educational setting and the mental health provider, as well as an administrative staffing process to ensure that issues are identified and addressed in an effort to maintain and enhance the program. Another venue that allows for a liaison process to occur at the local level is through the multiple needs process. Each county has a local multi-needs team that has representatives from mental health, child welfare, juvenile court, and the educational setting(s). The multi-disciplinary staffing allows for the child serving entities to work in a multi-directional process to engage needed care for the children and their families in which they all serve.

At the state level, within Mental Illness Community Programs, there are two dedicated positions for child and adolescent services and both interact as state level liaisons with all the state level child serving agencies. The Coordinator of MI C&A Services works with the Alabama State Department of Education (ALSDE) on issues of policy making and expansion of services, such as the SMHB Collaboration. The Coordinator also is a member of the State level Multi-Needs Case Review Committee. The MI C&A Resource Specialists works with anyone in which contact is made which includes the mental health providers, educational systems, and family members. This position ensures that the local parties identified are linked for coordination as to assure that identified children are connected to the local available mental health services.

7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

The age cut off for SED with ADMH is age 18. ADMH has flexibility for an individual to continue with C&A services in the mental health provider system but it hinges on the ability of the provider to continue to provide the care. If a young adult is moving into the adult system, such as completing school, going to college, getting a job, there would be a transfer of services from the C&A provider network to the adult services within the provider system. The gap that is sometimes experienced is that the young adult will now need to meet the SMI criteria and there are times this is an obstacle. For young adults who are still involved with children serving life experiences, such as still in high school, involved with DHR and/or juvenile court, the provider can maintain the mental health services with the C&A service network. The primary obstacle is ensuring the staff who is providing the treatment carries necessary certification/training approvals. This is typically needed for specialty services such as case management and In-home teams. In regard to residential services, there is only one residential treatment facility, under the certification/contract with ADMH, that focuses on transitional age. The age for this program is age 17-22. The CANS was developed with a Transitional component as to

allow for services and care to remain with the C&A service provider network when identified as most beneficial.

Section IV: Environmental Factors and Plan: 19. Pregnant Women and Women with Dependent Children

Not Applicable for MI Block Grant. Please refer to the SA Block Grant Application for this section.

Section IV: Environmental Factors and Plan: 20. Suicide Prevention

Alabama Suicide Prevention and Resource Coalition (ASPARC).

In 2001, the Commissioner of the Alabama Department of Mental Health and the State Health Officer of the Department of Public Health (ADPH) joined forces to establish the Alabama Suicide Prevention Task Force (ASPTF). In response to identified state needs, ASPTF would function to: (1) promote recognition of suicide as a problem affecting Alabama; (2) outline a strategy for the prevention of suicide in Alabama; and (3) identify federal, state, and local resources to support implementation of Alabama's Suicide Prevention Plan. Consisting of twenty seven (27) representatives of multidisciplinary public and private agencies, members of the faith community, as well as survivors, ASPTF published the State's first Suicide Prevention Plan in 2004. ADMH has maintained active representation on ASPTF since its inception.

The Alabama Suicide Prevention Task Force (ASPTF) reorganized during FY10. Evolving from task force status to a structured non-profit membership organization with a governing board, the ASPTF became the Alabama Suicide Prevention and Resource Coalition (ASPARC). ASPARC became a recipient of the Garrett Lee Smith Memorial Act grant in 2012. Thus, efforts have focused on the planning and implementation of the grant which has focused on providing QPR gatekeeping training and Lay My Burdens Down (LMBD). Ninety-nine (98) people in eleven (11) venues (colleges, high schools, churches, and social services and child focus agencies) have received QPR training. LMBD has been presented to 476 people. Through contributions of ASPARC members, a special edition on suicide were published in the peer reviewed Alabama Counseling Association Journal. This special edition is included in the attachments. At present ASPARC is planning for its annual meeting to be held on September 27, 2013.

ADMH continues to serve as an active participant in ASPARC activities, with a member of its staff elected to serve as its first president in 2010. The organization sought and attained 501(c)(3) Tax Exempt Status in 2011. The 1st Annual meeting was held September 14, 2011 in honor of Suicide Prevention Week. The 2011-2012 board consists of eleven members, representing the fields of social work and counseling, multiple universities, mental health, public health, numerous crisis centers, and the military. In addition to the board, ASPARC has membership, representing survivors, family members, hospice, students, private practice, counseling / treatment facilities, and education. ASPARC board has discussed approaching the Tribal communities for inclusion but these efforts have not yet been implemented.

For twelve (12) years ADMH has worked collaboratively with others to develop and implement strategies to prevent suicide in Alabama. Yet, suicide continues as a significant public health problem that impacts hundreds of families in this State each year. A recent news report indicates the suicide rate in Alabama reached an all-time high of 14.9 suicides per 100,000 people in 2013, as reported by the Alabama Department of Public Health. This rate was higher than that of the U.S. rate. Thus, the ADMH identified "Suicide

Prevention" as a priority to in Section II of this Block Grant Application when the spike began in FY12. The Office of Prevention identified as a goal to prevent suicides and attempted suicides and continues to have this as a goal for prevention provider planning. To address this goal the following objective that is underway is to promote the prevention of attempted suicides and deaths by suicide among those at risk for suicide. The action steps that have been in progress to meet this goal and objectives are: participation and collaboration with the suicide prevention task force, educate the prevention system on suicide and effective practices and resources for the prevention of suicide; ensure prevention plans address suicide, and prevention and reduce suicides among populations at high risk. Having suicide as a target of focus for prevention strategy implementation allows prevention providers to address high risk and vulnerable populations for this public health issue. Nineteen percent of the prevention provider agencies addressed suicide in FY2015 through use of Alternatives, Community Based Processes, Education, Environmental, and Information Dissemination strategies. One community example was the use of social media, community outreach events, town hall forums and public awareness campaigns to disseminate information on suicide to a six county catchment area. At the state level, the ADMH has continued its relationship with the suicide prevention task force with board membership, active meeting participation, collaboration on the Garrett Lee Smith (GLS) grant, and attendance at suicide conference. ADMH sponsored suicide gatekeeper training, QPR (question, persuade, refer) in April 2014 to the prevention provider network. In September 2014, during Suicide Awareness week, daily prevention messaging was disseminated to the statewide provider network on suicide. Suicide was indicated in the proposed approach for the Partnership for Success discretionary grant that was awarded to the state and slated to being October 2016. Through this grant, the following aims are desired. Our agency plans to collaborate and coordinate efforts directly related to suicide with the University of West Alabama prior to the culmination of its GLS grant on 9/29/16 and a local prevention provider. Specifically, a representative from the university will be invited to become a member of the State Prevention Advisory Board. Continued workforce development opportunities will be coordinated throughout the state for clinical providers. Targeted technical assistance sessions on focusing strategies toward addressing suicide prevention will be coordinated and developed in collaboration with the local prevention and clinical providers to ensure prevention planning addresses suicide, as well as suicide screening and assessment, are occurring and individuals are referred for treatment. At the community level, PFS sub-recipients will be tasked with updating their existing needs assessments that were developed during the SPF-SIG. The updated needs assessment process will include suicide as a construct for assessment in addition to the existing substance related constructs (alcohol and/or drug related motor vehicle crashes, substance abuse treatment admission, graduation rates, poverty). The existing EBP Workgroup will work with PFS sub-recipients to provide T/TA to assist in the selection of evidence based policies, programs, and practices focused on suicide prevention.

ASPARC began revision of Alabama's 2004 Suicide Prevention Plan in June 2010 and the revisions were finalized in late 2011-2012 denoting a three year plan. A draft five year plan is currently under development and was began in 2015. This plan is provided below.

The 2015 State Plan (DRAFT)

The 5 Year Alabama State Plan for Suicide Prevention provides state-specific recommendations that include Strategic Directions, Objectives and Strategies that align with the 2012 National Strategy for Suicide Prevention. The strategies outlined in this plan can be supported by ADPH, ASPARC, the Alabama Chapter of the AFSP, crisis centers, and colleges and universities throughout the state.

Strategic Direction

- Healthy and Empowered Individuals, Families, and Communities
- Clinical and Community Preventive Services
- Treatment and Support Services
- Surveillance, Research, and Evaluation

Goals

1) Integrate and coordinate suicide prevention activities in multiple sectors and settings across the lifespan.
2) Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.
3) Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery
4) Promote responsible media reporting of suicide, and the safety of online content related to suicide.
5) Develop, implement, and monitor best practice-based programs that promote wellness and prevent suicide and related behaviors such as QPR and other best practice first responder training programs.
6) Promote strategies to reduce access to lethal means of suicide among individuals and groups with identified suicide risk.
7) Provide training to schools, community, clinical and behavioral health service providers on the prevention of suicide and related behaviors.
8) Promote suicide prevention as a core component of health care services.
9) Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors. (8 and 9 seem the same to me).
10) Provide care and support to individuals affected by suicide deaths or suicide attempts, and implement community best-practice based postvention strategies to help prevent further suicides.
11) Increase the timeliness and usefulness of national, state, and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.
12) Promote and support research on suicide prevention.
13) Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

<u>Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities</u>

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings across the lifespan

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.

Strategy 1.1.1: Increase the number of local, state, professional, and faith-based groups that integrate suicide prevention activities into their programs.

Strategy 1.1.2: Strengthen collaborations across state agencies to advance suicide prevention.

Strategy 1.1.3: Strengthen collaboration between public-private partnerships to advance suicide prevention.

Strategy 1.1.4: Actively and visibly promote suicide awareness, education and outreach within schools and on college and university campuses.

Strategy 1.1.5: Incorporate suicide prevention training into professions that have exposure to traumatic events (e.g., law enforcement, EMS, fire and rescue, emergency department staff).

Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state, county, tribal, and local levels.

Strategy 1.2.1: ADPH and ASPARC will coordinate three regional suicide prevention annual trainings to promote suicide prevention collaboration efforts throughout Alabama. (Sounds good but I'm not sure what this means).

Strategy 1.2.3: ADPH, ASPARC, AFSP, and other interested organizations will coordinate and convene stakeholder meetings to assess needs and resources, and update the state suicide prevention plan in 2020.

Strategy 1.2.3: ADPH, AFSP, and local crisis center partners will encourage Local Education Agencies (LEAs) and other relevant education agencies to adopt and maintain suicide prevention policies.

Strategy 1.2.4: ASPARC will promote outreach and education through the Alabama Comprehensive Suicide Prevention Online Resource Directory (http://legacy.montevallo.edu/asparc/).

Strategy 1.2.5: ADPH will promote suicide awareness within different media outlets around the state.

Objective 1.3: Sustain and strengthen collaborations across agencies and organizations to advance suicide prevention.

Strategy 1.3.1: ADPH and partners will educate local, state, professional, volunteer, and faith-based organizations about the importance (necessity?) of integrating suicide prevention activities into their programs.

Strategy 1.3.2: Strengthen and expand partnerships with agencies that serve individuals at higher risk of suicide.

Objective 1.4: Develop and sustain public-private partnerships to advance suicide prevention.

Strategy 1.4.1: Utilize the resources of the National Action Alliance for Suicide Prevention (http://actionallianceforsuicideprevention.org/), a public-private partnership dedicated to advancing the National Strategy for Suicide Prevention.

Strategy 1.4.2: ADPH, crisis centers, and ASPARC will partner with state hospitals to distribute handouts to local emergency departments addressing suicide-proofing your home, what happens after a suicide, etc.

Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.

Strategy 1.5.1: Encourage businesses and employers to ensure that mental health services are included in health plans and encourage employees to use these services as needed.

Strategy 1.5.2: Encourage suicide screening questions on intake forms in primary care and other health care visits.

Goal 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

Strategy 2.1.1: Design suicide prevention, education, and awareness messages, each tailored to specific and diverse audiences that convey messages of help, hope, and resiliency. http://www.sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf and http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/

Strategy 2.1.2: Develop suicide prevention messages for teacher, administrators, students, and parents about resources available for referrals and mental health screenings.

Strategy 2.1.3: ASPARC and AFSP will identify and implement suicide prevention strategies for faith-based settings.

Strategy 2.1.4: AFSP will promote and support “community walks” as a way to increase suicide prevention and awareness.

Objective 2.2: Reach policymakers with dedicated communication efforts.

Strategy 2.2.1: AFSP will educate policymakers on effective suicide prevention efforts.

Strategy 2.2.2: AFSP will advocate for and support increased opportunities and funding initiatives for suicide prevention activities.

Strategy 2.2.3: ADPH will develop fact sheets for the public and at-risk groups about suicide, including talking points and data.

Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

Strategy 2.3.1: Integrate new technologies in suicide prevention programs (such as?).

Objective 2.4: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

Strategy 2.4.1: Increase public awareness of the role of the national and local crisis lines in providing services and support to individuals in crisis.

Strategy 2.4.2: Promote the use of new and emerging technologies such as tele-health, chat, and text services, websites, mobile applications, and online support groups for suicide prevention communications including follow-up communication for persons successfully intervened.

Strategy 2.4.3: Crisis centers will provide services and literature to families/significant others in discharge planning after a suicide attempt has occurred.

Strategy 2.4.4: Offer suicide prevention and awareness trainings to agencies working in the community. (SEEMS REDUNDANT)

Strategy 2.4.5: Crisis centers will provide training to local youth in the school setting. (Lifelines training curriculum from Hazelden)

Goal 3: Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.

Strategy 3.1.1: ADPH will develop and disseminate media promoting means restriction, including safe medication storage and firearm safety.

Strategy 3.1.2: ADPH and partners will educate individuals and families on building strong, positive relationships with family and friends.

Strategy 3.1.3: Colleges and universities will integrate trainings to educate faculty, student services, and resident advisors about identifying students and other individuals on campus who are at risk for suicide.

Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders

Strategy 3.2.1: Promote and participate in community awareness campaigns to reduce stigma and to increase access.

Strategy 3.2.2: ASPARC and AFSP will present information about faith-based suicide prevention strategies to promote mental health, increase understanding of mental and substance use disorders, and eliminate barriers to help seeking individuals.

Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is real and possible for all.

Strategy 3.3.1: Develop a variety of age-appropriate materials to educate on mental health issues for children, teens, and adults.

Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illness and the safety of online content related to suicide.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

Strategy 4.1.1: ADPH and crisis centers will disseminate *Recommendations for Reporting on Suicide* to news and online organizations. http://reportingonsuicide.org

Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of suicide and other related behaviors.

Objective 4.3: Develop, implement, monitor, and update guidelines on the safety of online content for new and emerging communication technologies and applications.

Strategy 4.3.1: Update recommendations related to suicide prevention as new media tools come into widespread use.

Objective 4.4: Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

Strategy 4.4.1: ADPH and crisis centers will distribute national guidelines to journalism and mass communications schools in Alabama.

Strategic Direction 2: Clinical and Community Preventive Services

Goal 5: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.

Strategy 5.1.1: ADPH, ASFP and ASPARC will engage stakeholders across the state to raise awareness and educate the community to promote wellness and prevent suicide.

Strategy 5.1.2: ASPARC will convene regular meetings for all state partners working to promote suicide prevention.

Strategy 5.1.3: Colleges and universities will promote and encourage suicide prevention efforts on campuses.

Strategy 5.1.4: ASPARC and crisis centers will **carry out** training of school staff (e.g., school nurses, school counselors, administration, bus drivers, social workers, school psychologists, resource officers) and faculty to increase knowledge of warning signs and suicide prevention efforts.

Strategy 5.1.5: ASPARC will annually update a link and listing of best practice-based suicide prevention programs in the Alabama Comprehensive Suicide Prevention Online Resource Directory (http://legacy.montevallo.edu/asparc/).

Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors

Strategy 5.2.1: ADPH and partners will provide education, training, and resources **about** the signs and symptoms of suicide and suicidal behaviors and how to take action to obtain help.

Strategy 5.2.2: ADPH and partners will identify groups at risk and work with various stakeholders to implement suicide prevention policies and programs that address the needs of these groups.

Strategy 5.2.3: ASPARC will train employees and supervisors to recognize coworkers in distress and respond appropriately, using information available from the Action Alliance for Suicide Prevention web-page.

Strategy 5.2.4: Crisis centers, colleges, and universities will make sure that students at risk of suicide have access to mental health and counseling services and are encouraged to use those services.

Strategy 5.2.5: Crisis centers will provide suicide awareness and prevention training to school aged students. (e.g., Hazelden's Lifelines Curriculum)

Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

Strategy 5.3.1: ADPH and partners will provide education, training, and resources on the signs and symptoms of suicide and suicidal behaviors to nonprofit, community, workplace, and faith-based programs along with how and where to go for help

Strategy 5.3.2: ADPH and AFSP will identify groups at risk and work with various stakeholders to implement suicide prevention policies and programs that address the needs of these groups. (SAME AS 5.22)

Strategy 5.3.3: Crisis center, colleges, and universities will screen for mental health needs, including suicidal thought and behaviors and make referrals to treatment and community resources, as needed.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.

Strategy 5.4.1: AFSP will educate the general public and policy makers about the need for adequate funding and leveraging of resources to increase access to and delivery of best practice-based programs.

Goal 6: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

Objective 6.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

Strategy 6.1.1: Disseminate information on means restriction to mental health providers, professional associations, and patients and their families http://www.hsph.harvard.edu/means-matter/.

Strategy 6.1.2: ASPARC will educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, and others about the importance of **making increased** efforts to reduce access to lethal means among individuals at risk for suicide.

Strategy 6.1.4: Provide information and resources about the disposal of unwanted medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g., a medication lock box) if a member of the household is at higher risk for suicide.

Objective 6.2: Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Strategy 6.2.1: Promote firearm safety for people who reside with a minor.

Strategy 6.2.2: AFSP will provide educational information about firearm safety and suicide prevention to gun retailers, shooting clubs and ranges, law enforcement, military personnel, and veteran groups.

Objective 6.3: Develop and implement new safety technologies to reduce access to lethal means.

Goal 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.

Strategy 7.1.1: Provide education, training, and resources on the signs and symptoms of suicide and suicidal behaviors along with how and where to go for help.

Strategy 7.1.2: ADPH will promote the use of best practice gatekeeper programs.

Strategy 7.1.3: ADPH will provide technical assistance as needed to help LEAs develop suicide prevention plans.

Strategy 7.1.4: ASPARC and AFSP will identify suicide prevention strategies for faith-based settings, connecting with the National Action Alliance for Suicide Prevention's Faith Communities Task Force (http://actionallianceforsuicideprevention.org/task-force/faith-communities).

Strategy 7.1.5: Train employees and supervisors to recognize coworkers in distress and respond appropriately.

Strategy 7.1.6: ADPH, ASPARC, and crisis centers will train relevant school staff to recognize students at potential risk of suicide and refer to appropriate services.

Objective 7.2: Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

Strategy 7.2.1: Increase the capacity of health care providers to deliver suicide prevention services in a linguistically and culturally appropriate way.

Strategy 7.2.2: Provide primary care toolkits **for suicide prevention** to primary care providers. (http://www.sprc.org/for-providers/primary-care-tool-kit)

Strategy 7.2.3: Promote training in suicide prevention for social workers, nurses, and other health-related personnel.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions. This includes health professional graduate and continuing education.

Strategy 7.3.1: Integrate appropriate core suicide prevention competencies into relevant curricula (e.g., nursing, medicine, allied health, pharmacy, social work, education).

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

Objective 7.5: Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Strategy 7.5.1: Educate relevant agencies about the use of emergency management guidelines/protocols to deal with crisis situations.

Strategic Direction 3: Treatment and Support

Goal 8: Promote suicide prevention as a core component of health care services.

Objective 8.1: Promote the adoption of "zero suicides" as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

Strategy 8.1.1: Promote www.zerosuicide.com website in publications and communications about treatment and support services.

Strategy 8.1.2: Crisis centers and ASPARC will educate providers of health care and community support systems about adopting zero suicide as an aspirational goal, and promote the organizational readiness survey of the national action alliance for suicide. http://zerosuicide.actionallianceforsuicideprevention.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/OrganizationReadinessSurvey.pdf

Objective 8.2: Develop and implement protocols for delivering services **to** individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

Strategy 8.2.1: ADPH will develop and maintain a list of support groups or self-help groups within the state.

Strategy 8.2.2: Crisis centers will support Crisis Chat programs which provide teens in difficult situations a way to anonymously receive support.

Objective 8.3: Promote and enable timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Strategy 8.3.1: Disseminate information about the National Suicide Prevention Lifeline and other local or regional crisis lines.

Strategy 8.3.2: Promote the availability of online support services and crisis outreach teams through ADPH and ASPARC websites and crisis center social media outlets.

Strategy 8.3.3: ADPH will develop protocols and improve collaboration among crisis centers, law enforcement, mobile crisis teams, and social services to ensure timely access to care for individuals with suicide risk.

Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

Strategy 8.4.1: ASPARC and crisis centers will educate and improve follow-up communication and connection (e.g., phone, text) with dischargers after care.

Strategy 8.4.2: ADPH will identify mobile app technology to engage individuals in their treatment of care.

Objective 8.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Objective 8.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.

Strategy 8.6.1: ASPARC and ADPH will hold suicide prevention meetings to enhance linkages among providers of primary care, mental health, and substance abuse services and community-based programs, including peer support programs.

Objective 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

Objective 8.8: Develop collaborations between emergency department care and hospital staff when appropriate, and promote rapid follow-up after discharge.

Strategy 8.8.1: Crisis centers will improve follow-up measures after discharge, such as status inquiries and caring letters, postcards, texts, and letters.

Goal 9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objective 9.1: Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.

Strategy 9.1.1: Crisis centers will educate middle-school aged children about suicide, suicidal ideation or depression through age appropriate programs (e.g., Hazelden's Lifelines Curriculum)

Objective 9.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.

Strategy 9.2.1: ADPH and partners will educate students in training to become mental health, social services, or heath care providers with respect to the identification and treatment of individuals at high risk for suicide.

Strategy 9.2.2: ADPH will increase community suicide prevention and awareness education campaigns to increase patient awareness and self-advocacy to receive optimal care.

Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

Strategy 9.3.1: ADPH and partners will **carry out** suicide awareness, prevention, and education to demonstrate the effectiveness of preventative treatment.

Objective 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

Strategy 9.4.1: ADPH and crisis centers will engage family members and significant others about appropriate steps they can take to support individuals at suicide risk during treatment and/or after discharge from an ED or inpatient unit through follow-up and educational materials.

Objective 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental and/or substance use disorders.

Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

Objective 9.7: Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

Strategy 9.7.1: Implement best practice-based recommendations related for assessment and treatment of those identified with suicidal thoughts and behaviors. www.sprc.org/bpr and www.samhsa.gov.

Goal 10: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Objective 10.1: Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implantation of these guidelines at the state/territorial, tribal, and community levels.

Strategy 10.1.1: Encourage mental health services be offered to employees including grief counseling for individuals bereaved by suicide.

Strategy 10.1.2: ASPARC will identify, maintain, and distribute suicide awareness, prevention and outreach resources via their Resource Directory.

Strategy 10.1.3: Crisis centers and ASPARC will educate community members in suicide awareness and prevention programs (QPR).

Objective 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

Objective 10.5: Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Strategy 10.5.1: Provide support to professional caregivers in communities and schools after a patient or a colleague dies by suicide.

Strategy 10.5.2: ADPH and ASPARC will maintain a list of bereavement groups and suicide peer support groups.

Strategic Direction 4: Surveillance, Research, and Evaluation

Goal 11: Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Objective 11.1: Improve the timeliness of reporting vital records data.

Objective 11.2: Improve the usefulness and quality of suicide-related data.

Objective 11.3: Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

Strategy 11.3.1 ADPH will collaborate with The Department of Mental Health about improving capacity to routinely collect, analyze, and report on mental health, substance abuse, and suicide-related data.

Objective 11.4: Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors related risk factors, and exposure to suicide.

Strategy 11.4.1 ADPH will review and make recommendations to Alabama Youth Risk Behavior Surveillance System Survey and Behavioral Risk Factor System Survey to include additional questions that will provide additional suicide prevention data.

Goal 12: Promote and support research on suicide prevention.

Objective 12.1: Develop a national and regional suicide prevention research agenda with comprehensive input from multiple stakeholders

Strategy 12.1.1: Support suicide-related research, including research on the risk and protective factors for suicide among different groups.

Strategy 12.2.2: Form partnerships with higher education partners to promote and support suicide prevention research.

Objective 12.2: Disseminate the national suicide prevention research agenda.

Strategy 12.2.1: Encourage Alabama Research Institutions to apply for national grants and research opportunities on suicide prevention, intervention, and postvention.

Objective 12.3: Promote the timely dissemination of suicide prevention research findings.

Strategy 12.3.1: Encourage suicide researchers to publish suicide-related research findings to share with state and local suicide prevention coalitions, health care providers, and other relevant practitioners.

Objective 12.4: Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

Strategy 12.4.1: ASPARC will frequently update the Alabama Comprehensive Suicide Prevention Resource Directory (http://legacy.montevallo.edu/asparc/) with the most recent suicide-related research, toolkits, websites, databases, etc.

Goal 13: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Objective 13.1: Evaluate the effectiveness of grant-related suicide prevention interventions.

Strategy 13.1.1: Promote the evaluation of local and regional suicide prevention programs and practices and the synthesis and dissemination of findings.

Strategy 13.1.2: Promote workplace evaluation of effectiveness of workplace wellness initiatives aimed at reducing the risk of suicide.

Strategy 13.1.3: Support evaluation efforts to assess knowledge gains and increases in self-efficacy.

Objective 13.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.

Strategy 13.2.1: Disseminate evidence for suicide prevention interventions.

Strategy 13.2.2: Encourage colleges and universities to share information on suicide prevention efforts.

Objective 13.3: Examine how suicide prevention efforts are implemented in different states, territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.

Strategy 13.3.1: Collect data to plan and implement successful youth suicide prevention programs.

Strategy 13.3.2: Examine policies and procedures for universities with low suicide rates for effectiveness.

Strategy 13.3.3: Promote and share already existing national resources to address interventions.

Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

Strategy 13.4.1: ADPH will assess the impact of the National Strategy for Suicide Prevention, outlined by the Alabama State Plan, in attaining the ultimate goal of Zero Suicide in Alabama.

Section IV: Environmental Factors and Plan: 21. Support of State Partners

ADMH partners with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, Department of Corrections, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements or informal relationships. As in the case of most states, Alabama has experienced fiscal challenges. Strained resources and the loss of a number of veteran state staff through accelerated retirement and downsizing has increased the workload on existing staff. Moreover, with the election of a new Governor, changes in leadership in most departments of state government occurred, especially with ADMH who has experienced a change in leadership of Commissioner four times since January 2011. As such, although ADMH has a good working relationship with partners, framing those relationships in a deliberate and collaborative fashion toward meeting the expectations of SAMHSA and aligning various departmental priorities with those objectives remain challenging at times. ADMH is working toward the transformation process by realigning and restructuring the process with longstanding partners and enhancing and developing the process with potentially new and less involved partners.

ADMH administers a wide range of services to adult and children/adolescent consumers in the community and at state institutions; regulates care and treatment providers; and consults with local, county, and public and non-profit agencies. The Department's responsibilities span a large number of program areas as outlined in Section II- Planning Steps - Step 1- Assess the strengths and needs. Other state departments work closely with the State Mental Health Authority on a regular basis including the following:

Primary health and mental health services

Medicaid:

The Alabama Medicaid Agency is a state/federal program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, individuals with disabilities and nursing home residents. These individuals must meet certain income and other requirements. ADMH has had a long-standing working relationship with the Alabama Medicaid Agency and is already fully engaged with the Medicaid Agency on planning for health care reform.

Below are areas of focus involving the Alabama Medicaid Agency:

Health Insurance Exchange:

Despite previously supporting Alabama's implementation of a state-based health insurance exchange, Governor Robert Bentley announced on November 13, 2012, the state will default to a federally-facilitated exchange. Prior to the decision, Governor Bentley issued Executive Order 17 which created the Alabama Health Insurance Exchange Study Commission to recommend how Alabama should establish a health insurance exchange. The Governor appointed an Executive Director of the Alabama Health Insurance Exchange to work with stakeholders and other state agencies on implementing the recommendations of the Commission. After meeting for three months, the 15-member Health Insurance Exchange Study Commission released final recommendations in late November 2011 to the Governor and Legislature endorsing the establishment of the "Alabama Health Insurance Marketplace." Additional recommendations included, establishing a new quasi-public authority to operate the exchange, following a free market facilitator model, establishing one administrative entity to oversee both the individual and small business exchanges while keeping the risk-pools for both separate, and funding the exchange through fees on all products sold in the individual and small group markets inside and outside the exchange. In May 2012, the Governor threatened to veto a bill establishing a state exchange, which passed in the House, if it cleared the Senate before the Supreme Court ruled on the constitutionality of the Affordable Care Act (ACA). The bill failed at the close of the 2012 legislative session, as did a similar bill in 2011. The ACA requires that all non-grandfathered individual and small-group plans sold in a state, including those offered through the Exchange, cover certain defined health benefits. Since Alabama has not put forward a recommendation, the state's benchmark Essential Health Benefits (EHB) plan will default to the largest small-group plan in the state, Blue Cross Blue Shield of Alabama 320 Plan PPO.

Electronic Health Record:

A Web site to encourage public involvement as Alabama develops a statewide electronic health record system is now available at www.onehealthrecord.alabama.gov as well as a link on the Alabama Medicaid Agency website. The site has been established as a central point for citizens to learn about and become involved in the state's efforts to use new technology to reduce duplication, increase efficiency, improve patient health outcomes, prevent fraud and abuse, and lower health care costs. Alabama recognizes the benefits that can be achieved through a secure, interoperable exchange of electronic health information that ensures the right information will be available to the right provider at the right time which will improve the quality, safety and efficiency of health care delivered to Alabama patients. The website provides details on the state's plans for a statewide health information exchange, including the work done by the Alabama Health Information Exchange Commission and its six workgroups, links to a separate but related effort to encourage physicians and hospitals to adopt, implement or upgrade to certified information technology systems, and links to the state's federally-supported Regional Extension Center at the University of South Alabama.

Medicaid Expansion:

Governor Robert Bentley announced in November of 2012 that Alabama would not participate in Medicaid expansion because of funding. Governor Bentley did not believe the Affordable Care Act was a "workable solution," and reaffirmed his stand against accepting a federal offer to expand Medicaid in the state. Governor Bentley has indicated that he doesn't want to expand a broken system. He is optimistic that Medicaid reform, which he signed into law in June 2013, will go a long way toward the solutions needed in Alabama. The reform employs a managed care overlay

to the system, in hopes of greatly reducing costly medical encounters by Medicaid users. In December 2014, Governor Bentley suggested that he might be open to an alternative option for expanding Medicaid in Alabama. Governor Bentley had previous opposed expanding the state-federal insurance program, but he says creating a state-designed program that uses the federal Medicaid expansion dollars may be an option for his state at some point, especially as Medicaid Reform progresses within the state of Alabama. At present date, Medicaid Expansion has not occurred on Alabama. Alabama is one of about 19 states so far that is not accepting the federal waiver for Medicaid expansion.

Medicaid Reform:

Medicaid reform legislation that would ultimately restructure the state's health care delivery system for low-income citizens (SB340) won approval in the Alabama Senate on April 25, 2013 and in the House on May 7, 2013. Governor Bentley held a ceremonial bill signing June 6, 2013 for Senate Bill 340, a measure that will help increase efficiency in Alabama Medicaid while also helping improve patient care. The approved bill is based largely on the earlier recommendations of the Alabama Medicaid Advisory Commission which was appointed by Governor Bentley to improve Medicaid's financial stability while also providing high-quality patient care. The Commission recommended in January 2013 that Alabama be divided into regions, and that a community-led network (RCO) coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with Alabama to provide that care. The Commissioner of ADMH was one of the Commission members. The State Health Officer chaired the Medicaid Advisory Commission and is leading the Medicaid transformation effort.

Regional Care Organizations:
Regional Care Organizations (RCOs) are locally-led managed care systems that will ultimately provide healthcare services to most Medicaid enrollees at an established cost under the supervision and approval of the Alabama Medicaid Agency. State legislation passed in 2013 and updated in 2014 created the new managed care structure to enable Medicaid to move away from a volume-based, fee-for-service environment to a payment system that incentivizes the delivery of quality health care and improved health outcomes. In October 2013, as required by law, the state established five regions. Under the new structure, Alabama Medicaid will enter into contracts with RCOs to provide certain covered services for Medicaid patients at an established cost. Implementation of full-risk RCOs is slated to begin no later than October 1, 2016. At that time, Alabama Medicaid will pay a set of monthly amount to each RCO which in turn will be responsible for paying for all the RCO-covered services.

One of the most important responsibilities of the state is to ensure that RCOs are able to meet all the requirements required by law and comply with regulations developed to implement of the law. As of January 1, 2015, 11 organizations have been awarded probationary certification by the state, allowing them to work toward full implementation by October 1, 2016. Before full certification is awarded, each probationary RCO must demonstrate that they have a sufficient number of providers and provider types to provide RCO-covered services by April 1, 2015. By October 1, 2016, probationary RCOs must also demonstrate that they can meet the financial solvency and financial requirements. Once those milestones are met, RCOs will be subject to a readiness review period

during which the state will determine if they are able to provide services to fulfill the obligations of a risk contract.

In order to implement RCOs in Alabama, the federal government must approve an exception, or waiver, to the existing program. This will be done in the form of an 1115 Waiver. This process started with the completion of an 1115 Waiver Concept Paper that had to be submitted to CMS for approval prior to completing the 1115 Medicaid Demonstration Waiver. The concept paper was submitted to CMS on May 17, 2013. ADMH participated with the Medicaid Workgroup and consultants on the language in the concept paper that was incorporated CMS for approval prior to completing the 1115 Medicaid Demonstration Waiver. Alabama's application for an 1115 Waiver was submitted on May 30, 2014. Since that time, Alabama Medicaid Agency officials have been in discussions with CMHS regarding the waiver. In September 2014, Alabama was one of three states selected by the National Governor's Association to receive technical assistance aimed at helping state use Medicaid to transform the delivery of services. A critical part of Alabama's waiver request is its request to use federal funds that are expected to be saved over the five years of the waiver to support the state's transition to managed care. The Medicaid Agency has developed a link on their website www.medicaid.alabama.gov , Regional Care Organizations that is posting Important Notices regarding Collaboration.

2703 Health Home State Plan Amendment (SPA):

In 2012, Medicaid partnered with the state agencies involved with Optional Medicaid services (Rehab, TCM, Waiver) to complete a 2703 Health Home State Plan Amendment (SPA). For the SPA to be approved, SAMHSA had to first approve the plan as to verify that behavioral health was written into the plan. SAMHSA conducted an interview/evaluation with ADMH in 2012 and agreed to the components of the 2703 SPA and indicated it was one of the few applications they had reviewed that demonstrated having bi-directional mental health and substance abuse care coordination/care management at a more integrated level. The SPA remained under review with CMS until May 2013 when finally approved. ADMH reached out to the Alabama Medicaid Agency to set up meetings to determine how the ADMH providers would participate with the implementation of the 2703 SPA as it pertains to mental health and substance abuse care. In 2013, the entire Medicaid process became a focal point of legislative focus and the Governor steered the state toward Medicaid Reform. It was determined that the Health Homes implemented in the four initial sites were proving to be a cost effective process to manage both clinical care of individuals and financial cost savings. At the root of the Medicaid Reform are the goals of the Health Homes: provide quality-driven, cost effective, culturally appropriate, and person- and family-centered health home services and coordinate Primary Medical Providers (PMPs) with Behavioral Health Providers in the Region to ensure delivery of best practices for integration and care management of chronic conditions. On April 1, 2015, the Health Home program expanded statewide to be managed by six of the eleven probationary RCOs who submitted qualifying proposals for their respective regions. On October 1, 206, the Health Home program will be incorporated into the full risk RCO's operation. This interim step is designed as a building block for probationary RCOs that are working toward full certification by facilitating network development and providing resources while offering the probationary RCOs an opportunity to demonstrate that they have the resources to manage patients in their region.

Medicaid Quality Assurance Committee:

State law required the formation of a Quality Assurance Committee comprised of practicing healthcare professionals, 60 percent of which must be physicians. ADMH has a representative on the Medicaid Quality Assurance Committee. This group approved 42 quality measures that will be used for monitoring RCOs' performance, 10 of which will be incentivized under the new managed care system. All but one of the 42 measures are nationally recognized and validated which will allow Alabama to compare its performance to other states and national benchmarks. The measures not only include metrics related to diabetes, asthma, and well-child, but mental and behavioral health, care coordination and if care is provided in the most appropriate location. ADMH worked closely with the committee to provide recommendations on the behavioral health measures. Of the 42 measures, 8 are mental health measures and 4 are substance use/abuse measures.

Medicaid Reform impact on ADMH:

ADMH continues to work directly with members of the Alabama Medicaid Agency, Alabama Hospital Association, the State Health Officer, the different consultants, ADMH providers, and ADMH internal committees, as well as the Disability Leadership Coalition, in regard to the multi-faceted areas of the Medicaid Reform process as to ensure that the mental health and substance abuse consumers we serve are being included for their unique and specialty needs for services and care. ADMH continues to share our willingness to partner and collaborate with the Medicaid Reform as to provide the expertise and guidance as it pertains to the consumers with severe mental illness, serious emotional disturbances, and substance abuse issues that we serve. The consumers currently with MI needs, that have traditionally been served by ADMH MI certified and contracted providers, will be impacted by these changes in the system as they are included in the Medicaid Managed Care process that will be initiated on October 1, 2016.

ADMH has determined that having the voices of our consumers, family members, providers, and other stakeholders (to include Medicaid) was vital to provide instrumental feedback and guidance in these areas of Medicaid Reform. Through the ADMH Associate Commissioner's two coordinating sub-committees (Mental Illness and Substance Abuse) the ADMH Medicaid Integrated Care Workgroup was formulated. This workgroup conducted several meetings to initiate the workgroup process and discuss planning ideas and objectives in 2013. Dr. Bell-Shambley requested that a small group of the ADMH Medicaid Integrated Care workgroup to meet to address the Mental Illness issues that are arising as it pertains to ADMH and Medicaid Reform. The initial focuses have been on: Medicaid Rehabilitative services, ADMH Commitments, and clarification needed around these areas. This group has been meeting monthly since November 2014. Future meetings will focus on the legal mandates of ADMH, dollars necessary to meet ADMH statutory requirements, and the impact of the consumers we serve with SMI/SED who are uninsured. Through the Medicaid Reform process, it is providing a platform for ADMH reform as well as to ensure that as the state of Alabama moves to a more coordinated system, the process does not develop an unintentional unhinging of the ADMH mental health system of care that has been developed over the past decades.

Money Follows the Person (MFP) Initiative:

Medicaid was awarded a MFP Rebalancing Demonstration Grant for which two populations have been targeted: Target 1: will be individuals residing in Nursing Facilities, regardless of age or type of disability. Target 2: will be individuals residing in State Operated Psychiatric Hospitals who are currently receiving Medicaid or who are Medicaid eligible. Approximately 400 to 600

individuals are expected to benefit for this initiative. The majority of these individuals (approx. 113) reside at the Harper Geriatric Psychiatry Center. For the purposes of addressing the needs of individuals with mental illness and ID/DD who transition for nursing facilities, the State is pursuing the development of an ACT II Waiver which will offer support and home based services not available in other service models. The MI/SA Division is working with ID/DD Division to develop ACT II Waiver services to support the MFP project. The purpose of the Home and Community-Based Services ACT Waiver is to enable individuals, who currently reside in a nursing facility, the opportunity to transition out of the facility and receive home and community based services in the community. A second target population would be individuals with intellectual disabilities currently being served on one of Alabama's other HCBS waivers whose condition is such that their current waiver is not meeting their needs and admission to an institution is eminent if the ACT Waiver were not an option to better serve their needs. Services are currently under development, but it is proposed to include supported employment and peer support services.

Medicaid Emergency Psychiatric Demonstration: in 2012, ADMH partnered with Medicaid and the Alabama Hospital Association in the Medicaid application for a 3 year CMS demonstration grant around the allowance of Medicaid payment for psychiatric care in a free standing psychiatric private hospital unit (IMD). ADMH provided the state match dollars for this demonstration. There were four inpatient psychiatric hospitals participating in the demonstration; EastPointe and BayPointe who began in July 2012 and Hillcrest and Mountain View who began in October 2012. In March/April 2015, the Alabama Medicaid Agency was contacted by CMS that the project would close 2.5 months early due to federal funding issues. There is a SB in Congress to secure approval for these demonstration states to continue for the next 2 years while CMS is completing is review of the demonstration. ADMH is working with AMA and ALAHA on next steps to sustainability.

Medicaid State Plan Amendments:

- Medicaid Rehab Option: ADMH has worked with the AMA for the last 5-6 years on making updates to the Rehab Option requested by ADMH. Due to issues with CMS, this was temporarily delayed. ADMH continues to express our need for this update as to expand Rehab service options that could include peers as professionals and employment opportunities. In May 2014, CMS made contact with AMA to get closure on the outstanding issues. A series of calls have occurred and AMA is hopeful for resolution. In February 2015, the state agencies that participate with Rehab Option came together to discuss the needed financial changes being mandated by CMS. AMA is to compile and bring the state agencies back together for review and submission to CMS. Once resolved, the Rehab Option SPA can be submitted.
- Targeted Case Management (TCM): ADMH has worked with the AMA for the last 5-6 years on ADMH requested changes to TCM Target 1 (SMI Adults) and Target 3 (SED Kids). ADMH requested and provided proposed language to add a new target – Target 9 for Substance Abuse Adults and Kids. Due to Medicaid having a current TCM amendment with CMS, no new amendment can be submitted until closure has occurred on the current issue. ADMH continues to express our need for these updates as it pertains to our continuum of care and the collaborative relationship with the health homes and the Medicaid Reform efforts.
- Medicaid Non-Emergency Transportation (NET): In June 2012, Medicaid decided to issue an RFP for transitioning the Non-Emergency Transportation Program from the current

administrative model to a broker model. Under the broker model, Medicaid would contract with a broker to arrange a pay for NET services. This process excluded the ADMH NET program. Under the Medicaid arrangement with ADMH, ADMH pays state share (50%). The RFP process occurred in June 2012 for vendors to submit proposals. Medicaid submitted the SPA in January/February 2013. CMS wanted to change how ADMH was addressing the Transportation process which would mean changing from an Administrative Claims process to a Service Claims process, which is ADMH's preference. ADMH and Medicaid finalized the process which began April 1, 2014 for the Substance Abuse NET billing process and June 1, 2014 for the Mental Illness NET billing process. AMA did not initiate the new NET process yet and will await to address with the Medicaid Reform/RCO process.

Alabama Department of Public Health (ADPH):

The purpose of the ADPH is to provide caring, high quality and professional services for the improvement and protection of the public's health through disease prevention and the assurance of public health services to resident and transient populations of the state regardless of social circumstances or the ability to pay. The ADPH works closely with the community to preserve and protect the public's health, to provide caring, quality services and serve the people of Alabama by assuring conditions in which they can be healthy. The ADMH works collaboratively with the following programs within ADPH.

- **The Office of Primary Care and Rural Health:**

The Office of Primary Care and Rural Health facilitates and participates in activities to improve access to health care services for all rural Alabamians with special concern for children, the elderly, minorities and other medically underserved vulnerable populations. They serve the following populations: Communities, Rural Health Clinics, Critical Access Hospitals, Small Rural Hospitals, Federally Qualified Health Centers, County Health Departments, Physician Practices, and Mental Health Centers. ADMH staff work closely with this Office in the designation of Health Manpower Shortage Areas and the placement of J-1 Visa physicians in mental health centers and state hospitals. ADMH partnered on a grant application that provided matching funds for placements of physicians and other mental health providers. Unfortunately, the 50% match requirement proved to be a significant barrier in times of declining funding.

- **Children's Health Insurance Program (SCHIP)/ALL Kids**:

Alabama was the first state to receive approval of their plan to implement the CHIP program under the new federal legislation. This plan was implemented in phases: (1) Medicaid Expansion of the SOBRA coverage for youth ages 14-19, effective February 1, 1998, (2) Benchmark Health Insurance for children, ages 0-19, in families between 100% and 200% of poverty, effective September 1, 1998, and (3) a self-insured "special needs" package of services. The third phase was implemented by a coalition of agencies – Public Health, Mental Health, Children's Rehabilitation Services, and BC/BS. The mental health component of the Children's Health Insurance Program, referred to as ALL Kids, was expanded in December 2002 and now mirrors the services available through the Rehab Option for those eligible for Medicaid. CHIP was reauthorized in April 2009. Through the provisions included in the Children's Health Insurance Reauthorization Act (CHIPRA), ALL Kids expanded eligibility to

include children in families with income up to 300% Federal Poverty Level. Previous income eligibility was up to 200% Federal Poverty Level. This was effective Oct. 1, 2009.

Blue Cross and Blue Shield of Alabama worked with ALL Kids to become compliant with Mental Health Parity and initiated new provisions, effective October 1, 2010. Essentially, limits for mental health related services have been removed as necessary to be comparable with medical services provided through the ALL Kids Plus benefit package which had previously been limited only to those who exceeded the Basic benefit package.

ALL Kids continues to enroll uninsured children with family income above the Medicaid limit up to 317% of the Federal Poverty Level, which is the newly established conversion threshold for Alabama per the Affordable Care Act (ACA). To prepare the state to meet the various changes required by the ACA, ALL Kids has partnered with Medicaid and other sister agencies in the development of a new joint eligibility and enrollment system which was implemented in October 2013.

As required by the ACA, effective January 1, 2014, 22,939 ALL Kids enrollees were transitioned to Medicaid. This group is referred to as MCHIP. ADMH participated in the transition planning process to ensure transitioning enrollees received needed behavioral health services without interruption. This MCHIP group covers uninsured children from 6 to 19 years of age with family income between 107 and 146 percent of the federal poverty level.

As of July 1, 2015, ALL Kids enrollment was 60,732 and MCHIP was 39,378, for a total CHIP enrollment of 100,110.

ALL Kids is Mental Health Parity compliant as well as meets the ACA preventive services requirements.

Primary Health Collaborations:

Alabama Primary Health Care Association (APHCA):

The APHCA was established in 1985 as a non-profit, professional trade association whose mission is to strengthen and expand Alabama's community health center network through service, technology, partnerships, advocacy and education so that Alabamians have access to quality primary health care. APHCA is governed by a Board of Directors comprised of one voting delegate from each organizational member and four non-voting representatives from the associate membership. As the voice for Alabama's community health centers (CHC), medically underserved and uninsured populations, APHCA is dedicated to the promotion of high-quality, family-oriented, culturally competent health care. APHCA represents the program, policy, and operational interests of more than 120 community-based health care centers providing almost one million primary care visits to over 300,000 individuals across Alabama. Alabama's community health centers had an overall economic impact of $150 million and supported 2000 jobs.

Over the last couple of years, staff of the APHCA has met with ADMH staff, the Executive Directors, and Clinical Directors of the provider networks to initiate the collaborative process. The

APHCA conference in 2010 had a track devoted to integration of primary and mental health care. Additionally, information regarding the new Health Resources and Services Administration Access Point and Capacity Expansion grants has been shared with mental health centers who are encouraged to work with the local Federally Qualified Health Center (FQHC) to develop joint applications. APHCA was a primary partner in the development and implementation of the Transformation Transfer Initiative, the foundation of which was improved collaboration between primary and mental health partners. Meetings continue to occur between FQHCs and CMHCs Executive Directors for the purposes of strengthening collaborations at a local level.

In FY11, through a USDA grant, the University of Alabama, School of Medicine, Tuscaloosa Campus partnered with rural clinics to provide telemedicine services and distance learning. One of the sites is Capstone Rural Health Center which provides primary health care, health promotion, disease prevention and managed care to all surrounding rural areas and have partnered with a local mental health center to the benefit of 6,000 mental health consumers. In addition, the College of Community Health Sciences and the Institute for Rural Health Research at the University of Alabama was also able to access grant funds to promote the use of telemedicine and offer educational opportunities for mental health employees through distance learning on various topics and to serve as a bridge between the mental health provider and the University of Alabama Autism Spectrum Disorders clinic.

American Academy of Pediatrics – Alabama Chapter (ALAAP):

The ALAAP is the only statewide member organization of pediatricians, with 750 members across the state, representing both academic and community pediatrics in both urban and rural areas. Alabama's pediatricians serve as the first line of healthcare for children across the state, and are many times the only professionals that many of the state's children come in contact with during their formative years. ALAAP Chapter members have an active voice on every state committee or collaborative effort whose mission is to serve the interests of children. The organization is a non-profit 501(c) 3 organization, operated by a volunteer board of directors and executive staff located at a central office in Montgomery.

ADMH has had a long-standing collaborative relationship with ALAAP. Throughout the past several years, ALAAP and ADMH, along with other state and community partners, have directly collaborated on several initiatives.

- Telemedicine – Due to the fact that more than 25 percent of Alabama's children receiving services in the public mental health system are prescribed psychotropic medications and are in need of ongoing care and monitoring, yet there is a significant shortage of child and adolescent Psychiatrists, in 2004, a telemedicine pilot project was launched in a rural MHC catchment area where this service previously did not exist. This project was a collaborative effort by ADMH, Children's Hospital, a local pediatrician, ALAAP, and the community mental health center and provided child and adolescent psychiatric services via the teleconferencing system set up at the local hospital. An evaluation component was added to provide necessary data to determine future goals and needs. This evaluation data led to the Alabama Medicaid Agency adding telemedicine to the Rehabilitation Option. Over the next several years, several C&A telepsychiatry projects were implemented. This model was further expanded to other locations in the state for adults and children/adolescents.

Since 2010, the Medicaid Agency, based in part on experience in the mental health system, now covers telepsychiatry under the Physician's Program in addition to the Rehabilitation Option. The use of telepsychiatry continues to expand in the state with mental health centers reporting a total of 38 counties in use for child/adolescent services as of August 2015.

- Child and Adolescent Psychiatric Institute (CAPI) - Collaboration also occurred between ADMH, pediatricians, ALAAP, and community mental health psychiatrists concerning appropriate child and adolescent psychiatric care, which led to a partnership with the Department of Public Health to allow for expansion of the Child and Adolescent Psychiatric Training Institute (CAPI) to include pediatricians. This partnership occurred for seven CAPIs, allowing community mental health psychiatrists and pediatricians the opportunity to receive continuing education training on best practices information regarding the treatment of children and adolescents with severe emotional disturbances. Attendees included community mental health center psychiatrists, pediatricians, acute care psychiatrists, and ADMH-certified residential treatment care facility psychiatrists. From these training institutes, several local communities have begun collaborative relationships and have co-located and/or integrated care, initiated the use or screening instruments, developed local resource guides, and explored other creative wrap services. Sadly, due to the budget deficits, funds for this training was eliminated.

- In early 2015, ALAAP began a five-year partnership with ADMH and the Alabama Partnership for Children as a sub-grantee for Project LAUNCH (Linking Actions for Unmet Needs in Children's Health). The purpose of Project LAUNCH is to promote the wellness of young children from birth to eight years by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. Alabama's Project LAUNCH is building on the vision of the Early Childhood Comprehensive Systems (ECCS) plan (Blueprint for Zero to Five), and other successful collaborative efforts to integrate programs that provide a complete range of developmentally supportive services to families with young children, and to expand and enhance evidence-based programs related to children's healthy development. The local implementation area is Tuscaloosa County. The core strategies include:

    - screening and assessment of young children – through the state Help Me Grow initiative training and support for primary providers (health care, early education, and home visiting) to use the ASQ-3/SE at regular intervals; develop a single point of referral and information and improve the roadmap for referrals; enhance 2-1-1

and Parenting Assistance Line for seamless and appropriate referrals; gather and analyze data to improve referral systems and identify service barriers

- integration of behavioral health into primary care settings – expanding the use of Social and Emotional Foundations of Early Learning materials and resources; technical assistance, training, and mentoring; training and resources to implement the ASQ-3/SE and appropriate referrals in primary care settings

- mental health consultation in early care and education, including training and mentoring for diverse early learning settings; improved access to needed interventions; and broad understanding of the social and emotional needs of young children and the negative impact of adverse childhood experiences

- enhanced home visiting with focus on social and emotional well-being by providing training and mentoring to existing and new home visitation programs; expanding evidence-based family strengthening and parent skills training – expanding and enhancing the Strengthening Families Initiative to the local implementation area including community training and resources; parent cafes; improved access to resources; parent leadership training and engagement; building family and community strengths to improve resiliency.

Interagency Collaboration

ADMH works collaboratively with other local and state adult and child serving agencies to develop systems that would integrate social services, education and criminal and juvenile justice with mental health services as to develop a more comprehensive system of care in the community. A variety of avenues have been utilized in the ongoing attempts to provide a system of integrated services. For child and adolescent services, in 1986, an interagency agreement creating the Interagency Council on Youth (ICOY) was signed by all five state child-serving agencies to cooperate on improving services to children. From that time, several noteworthy interagency collaborations have been created not only between ADMH and a singular state agency, but with multiple agencies collaborating in conjunction. The early foundation of interagency collaboration seems to have paved a path that has allowed for expansion and enhancement of mental health services in a more creative process. However, the recognition is that much more is needed in the area of interagency collaboration to move to true transformation and restructuring of a system of care for adults, children/adolescents, and their families.

Criminal Justice Services

ADMH fosters collaborations with those in law enforcement, judiciary, and corrections at both state and local levels. ADMH was the recipient of a Bureau of Justice Assistance grant to improve coordination of services. Dr. Ron Cavanaugh, the Director of Treatment for Alabama Department of Corrections has engaged ADMH and the Council of Community Mental Health Boards to discuss the service needs and resources of prisoners who have reached end of sentence or who qualify for parole. In FY11, the Community Mental Health Clinical Directors hosted a number of Dr. Cavanaugh's treatment staff to address issues around access and care coordination for inmates

being released from prison. One challenge faced by both DOC and ADMH are inmates who are at end of sentence but for whom DOC feels are too symptomatic to be maintained in the community. Many individuals who fall within this description often end up being admitted into the State Psychiatric System and often pose barriers to community integration due to criminal history, sex offender status, and/or limited or no financial resources.

In FY12, the ADMH and DOC Commissioners brought together key decision makers of their staff to explore avenues to strengthen the care coordination and transition between our systems. The primary area of focus was on End of Sentence (EOS). There are two distinct paths that invovle mental health inmates: 1) Re-entry 2) EOS ADMH Commitment. In regard to EOS ADMH Commitment, through the probate commitment process, inmates may be committed to ADMH for treatment to stabilize their condition and then returned to DOC for continued serving of the sentence. Individual who are approaching the end of their sentence, and who have mental health disorders, and are determined to be in need of continued treatment upon release from prison can be probate committed to ADMH for inpatient treatment at the time their sentence expires. Review of the data for these type commitments over the last 7 years has shown that many of these individuals are treated and discharged to community placements after relatively brief periods of inpatient treatment. This data review has led to the development of a protocol process that can streamline this process and make better use of community resources where by mentally ill inmates can be triaged prior to the End of Sentence (EOS) date and linkages to community providers established for after-care and assistance with transition into the community. It is expected that this will reduce or eliminate the need for EOS commitments to state hospitals. In regard to Re-entry, ADMH has involved the community providers in this effort and this remains an area that needs further assessment as to strengthen and develop a more formalized process.

One of the areas identified that was vital in the care coordination between the Justice entities and the Mental Health entities was the need for appropriate and accurate data. In 2013, ADMH partnered with both Department of Corrections and Pardons and Paroles to develop two separate Bureau of Justice Administration grant proposals. ADMH, DOC, and P&P submitted a proposal to create the Alabama Secure Sharing Utility for Recidivism Elimination (ASSURE) web-portal through which will authorize personnel from ADMH, ABPP and DOC to retrieve supervision information regarding clients/inmates collected by other agencies. ASSURE will also include information from the risk and needs assessments conducted by each of the partner agencies as well as supervision information where applicable. ADMH also partnered with Pardons and Paroles to develop a BJA proposal that would implement a Substance Abuse and Mental health Activities supporting Recovery Team (SMART) in order to reduce individuals with mental illness from further involvement from the criminal justice system and to improve the safety of the community at large. SMART will address the lack of coordinated training and cross systems communication as it relates to individuals with mental illness or co-occurring disorders involved in the justice system.

Juvenile Justice/Alabama Department of Youth Services (DYS):

In 1987, an interagency agreement was negotiated and signed with the state's juvenile justice system, Department of Youth Services (DYS). This agreement governed the referral and assessment of problematic cases, which in the past had frequently resulted in protracted legal battles.

ADMH and DYS have been collaborating for many years. Collaborations have included, but are not limited to, the following:

- An Interagency task force called the Commission on Girls and Women in the Criminal Justice System. Established by a joint legislative resolution in 2006, the commission is studying the conditions, needs, issues, and problems of the criminal justice system in Alabama as it affects girls and women. The commission issued its recommendations in October 2007. In 2008, a Phase II/New Legislative Resolution occurred to extend the work of the Taskforce so that this group could oversee the implementation of recommendations.
- In 2007, an effort was made to continue to implement the strategic plan of the 2004 National Policy Academy on Improving Services for Youth with Mental Health and Co-Occurring Substance Abuse Disorders and bring together the efforts of other such initiatives currently underway in Alabama. ADMH partnered with DYS and two local counties (Jefferson and Morgan) to make application for the Models for Change Mental Health/Juvenile Justice Action Network sponsored by the MacArthur Foundation and coordinated by the National Center for Mental Health and Juvenile Justice. This grant application was not selected.
- For the past decade, the Annie E. Casey Foundation and counties around the country have focused on investing in a process call the Juvenile Detention Alternatives Initiative (JDAI). They set out to show that local jurisdictions could establish more effective and efficient systems that could safely reduce reliance on secure detention. The JDAI model has proven to be cost effective, improve public safety, improve efficiency, and promote good administration. JDAI is a process, not a conventional program, whose goal is to make sure that locked detention is used only when necessary. In pursuing that goal, JDAI restructures the surrounding systems to create improvements that reach far beyond detention alone. JDAI's primary target is youth who are in detention or at-risk to be detained in the future. With the vision of key leaders in Alabama, to include the previous Governor and previous Chief Justice-as well as strong advocacy from DYS, Annie E. Casey Foundation entered a partnership to strengthen juvenile justice in the state. In April 2007, a team of experts from the Casey Strategic Consulting Group provided technical assistance in Alabama. The introduction of JDAI in Alabama started in four counties – Jefferson, Montgomery, Mobile, and Tuscaloosa. In 2008, ADMH was invited by the two of the four local JDAI sites (Jefferson and Montgomery) to participate on the Executive Committee.

Administrative Office of the Courts (AOC):

AOC is charged with providing centralized, state-level administrative support necessary for the operation of the State's court system; the development of procedures and systems to enhance the operational capacity of the courts; and the collection and dissemination of information necessary for the development of policies to promote the more efficient operations of the courts. The major programs for which the Administrative Office of Courts assumes responsibility are: finance; personnel services; judicial education; legal research and assistance; automated program design and site implementation; imaging; inventory control; records and space management; judicial assignments; jury and case management; time standards and statistical data; uniform traffic ticket and complaint supply and accountability; magistrate appointment and education; trial court assistance; child support enforcement; Juvenile Court assistance; court referral programs; drug court and other problem-solving specialty courts and court planning.

ADMH and AOC have been collaborating for many years. Collaborations have included, but are not limited to, the following:

- In 2006, ADMH partnered with the AOC and received a grant to establish an Adult and Adolescent Mental Health/Juvenile Task Force. The task force(s) completed a needs assessment on the state and a gap analysis that led to the development of recommendations in a strategic plan. Many of the participants of the 2004 National Policy Academy participated on the Juvenile Task Force of this initiative. This grant ended in November 2007. However, the state applied for a Phase II funding for the Justice and Mental Health Collaboration Program which was submitted by ADMH This application was not awarded.
- In FY06, there was a proposed revision to the Alabama Juvenile Code of 1975. In April 2006, the Bill did not make it out of legislative committee. However, a Juvenile Code Legislative Subcommittee was appointed, with the development of specialized subcommittees to include a Mental Health Subcommittee. Primarily, the proposed revisions were to provide updates and clarify old terminology with emphasis on the delinquent statutes being in line with Federal regulations. In the 2007 Regular Legislative Session, a revised bill was introduced. That bill came out of committee, but, like most of the bills introduced during that session, did not reach a vote in either House. During 2007, a concerted effort was made to again review the bill with all of the interested groups and entities, along with the Alabama Law Institute. During this period, the bill's provisions were again revisited and revised to meet the concerns of the different groups and interests. In 2008, the draft legislation was once again presented and the Juvenile Justice Act of 2008 was signed into law by the Governor on May 8, 2008. While most of the changes in the law are procedural or involve only reorganization and clarification of current law, there are some changes that may impact each of the respective agencies (mental health, child welfare, education, juvenile justice). In an effort to assist partnering agencies, AOC organized meetings to discuss different state agency's training needs and ways that AOC may assist in meeting those needs. These efforts continued into FY09 with identified training needs developed and implemented to ensure agencies and communities were aware of changes as the Act became effective in two phases, January 2009 and October 2009.
- Also during the FY09 legislative session, HB 559, the amendment to the Juvenile Code, was signed by the Governor on May 21, 2009. This Act affirms the ADMH Commissioner's ability to designate a hospital/facility outside of the Department to provide services to minors and children with SMI or intellectual disabilities and to place these minors and children who have been committed to the department in said hospital/facility. It would also clarify the timeframe intended in the code as the necessary amount of time needed in notifying the department of final commitment hearings. These changes are in line with the recommendations of the Child and Adolescent Workgroup of the Systems Reconfiguration Task Force. An internal workgroup has been charged with drafting recommended language for a Request for Proposals process by the MI Associate Commissioner and ADMH Commissioner as to work toward complying with recommendations of the System's Reconfiguration Request for Proposals (RFP) regarding Bryce Adolescent Unit was issued August 2009. University of Alabama-Birmingham (AUB) Hospital's RFP was selected. A contract transferring the operation of the Adolescent Unit from Bryce Hospital to the University of Alabama in Birmingham

Department of Psychiatry and Behavioral Neurobiology was signed. The transfer was effective in October, 2010.

- ADMH submitted a joint application with AOC for a Department of Justice Planning and Implementation grant in 2009. The proposal focus was to establish design and outcome criteria for Juvenile Mental Health Courts. There has been increasing interests in mental health courts for juveniles and a few counties in Alabama have begun to provide diversion and alternative mental health programming through such mechanisms. The grant proposal would attempt to bring uniformity in the operation of these and any new courts so that their effectiveness can be compared and generalized across Alabama. In FY10, ADMH received this Planning and Implementation Grant from the Bureau of Justice Administration (BJA) to develop an evaluation component mechanism to evaluate mental health courts (adult and juvenile) in Alabama. The grant provided training and technical assistance opportunities to the state and various jurisdictions on public safety and treatment outcomes of individuals involved in mental health courts. The grant supported the development of a toolkit for courts and treatment providers to use and improved capacity to collect relevant data to determine outcomes within and across jurisdictions. The collaboration hosted the two statewide mental health court conferences in 2010 and in November of 2011.

Education, Rehabilitation, and Employment:

For adults, case managers and clinicians from the mental health centers work with local educational institutions and Vocational Rehabilitation Services offices to refer consumers for education and employment services. Consumers are provided basic educational services and pre-employment services in day treatment and residential programs. Outpatient consumers are referred to local GED classes and/or institutions of higher learning such as community colleges and universities based on the consumers' interests and abilities. Providers work with the Rehabilitation Services office to refer people for regular rehabilitation services as well as VR supported employment. The Department acknowledges employment is an essential element to Recovery for many consumers and therefore, hired an Employment Specialist dedicated towards the expansion of supported employment models for all ADMH target populations of which the initial focus was on those with Intellectual Disabilities. Due to the pressing need to transition from sheltered workshops towards competitive employment, the Employment Specialist was assigned to the Developmental Disabilities Division full-time. The MHSA Division staff enjoys a close collaborative relationship with the DD Division benefiting from the expertise of the ADMH-DD Employment Specialist. This Employment Specialist is a former career professional with the Alabama Department of Rehabilitation Services. His connections with ADRS and expertise in supported employment have well served the staff of MI Community programs. As a result, MI Community programs has forged collaboration with ADRS for piloting mental health based supported employment programs. Preliminary work in this area was provided by an Employment Development Initiative grant. Such 2011 activities supported by this grant included consumer and provider survey's as to barriers towards employment, Peer Support Specialist Train the Trainer training, a statewide stakeholder supported employment planning event, and a series of educational and motivational workshops: Work Works: An Essential Component to Recovery, conducted by George V. Nostrand, self-advocate and professional Employment Counselor. ADMH recently initiated the establishment of an Alabama Interagency Planning Committee for Supported Employment of which representatives from ADRS, the Alabama Department of Economic and Community Affairs (ADECA), Alabama Medicaid, Post-Secondary Education, and Workforce

Development participate. This interagency collaboration assures a coordinated effort to affect state policy and is active in advocating for the passage of Employment First legislation. In 2014, ADMH was awarded the SAMHSA Transforming Lives through Supported Employment grant. This grant supports the hire of a Supported Employment Trainer/Coordinator to assist with the implantation of the evidence-based supported employment model (Individual Placement & Supports) at two pilot locations. This model will focus on creating competitive employment opportunities for individuals with serious mental illness.

Alabama State Department of Education (ALSDE):

ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred school systems in the state. For numerous years, case managers, in-home intervention teams, and outpatient clinicians employed by the Community Mental Health Centers (CMHCs) have had frequent contact with the educational system on behalf of children with a serious emotional disturbance and their families.

- In FY99, the educational system identified a portion of At-Risk funding to develop school day treatment programs in conjunction with community mental health centers. This initiative enabled 10 additional community-based child and adolescent day treatment programs to be established statewide. Further efforts for training have occurred around educational laws, with special focus on Individual with Disabilities Education Act (IDEA). All day treatment programs had to undergo necessary training, education, and adaptations. Also, case managers, Juvenile Court Liaisons, and mental health clinicians are provided in-depth training around IDEA and special education laws provided by the Alabama Disabilities Advocacy Program (ADAP).
- Through the C&A Evidence-Based Practices (EBP) Workgroup, several EBPs have been researched and recommended for consideration, to include school based EBPs. Efforts have been initiated over the last several years to secure funding to initiate these EBPS to include budget requests and applications for grants both with ALSDE and with the University of Alabama. Also, the Department was granted a SAMHSA System of Care grant that involved three rural counties. Coping Power, a mental health/education EBP, was written into this grant as to implement this EBP in two of the three counties, as well as Positive Behavior Supports (PBS).
- Case managers and CMHC clinical staff assess their consumer's educational strengths and deficits and link consumers to training and other services necessary to enhance their educational and employment status. A variety of services are available to meet the individual educational and employment needs of adolescents transitioning into adulthood including adult education, literacy training, pre-employment services in day treatment programs, and specialized vocational and training services provided by the Department of Vocational Rehabilitation Services (VRS). For children and adolescents with a serious emotional disturbance, case managers and clinical staff have available the array of special education services provided within the educational system, as well as day-treatment programs which also contain a school component, or alternative school programs provided in other settings by mental health centers, the Department of Youth Services and some private, non-profit agencies. Case managers and clinicians work with the Rehabilitation Services office to refer people for regular rehabilitation services, as well as supported employment. Education and employment are key aspects of recovery for many consumers.

- In FY09, ADMH was invited to be a member of ALSDE's State Interagency Transition Team through the Special Education Division. The Interagency Transition Team is responsible for the development of a strategic plan that addresses issues surrounding transitional planning concerning special education students. In FY09, ADMH participated as presenters in the Auburn University's Annual Transition Conference. This was a panel discussion of the service array provided by each Division within ADMH and how these potential resources could be beneficial to the transition process. In FY10, ADMH was invited to present again. A panel presentation, with representatives from ADMH, a local provider, and two youth consumers, was conducted that focused on helping young people with mental health needs face individual and institutional challenges in transition. ADMH also presented similar information at ALSDE's MEGA Conference (Alabama Special Education) in July 2010 on similar transition issues for youth with SED. In May 2010, ADMH presented at the Educational hosted Annual Health and Human Resources Leadership Day, presenting on mental health resources with focus on the continuum of care.
- In FY11, key administrative staff from ADMH and ALSDE met to discuss potential collaborative opportunities in light of health reform and budgetary issues. ADMH and ALSDE identified the need for a deliberate strategy aimed at improving service quality within and continuity between the two departments. The aim is to achieve greater integration of mental health services between the mental health providers and the public schools and to increase the utilization of evidence-based practices. The integration of these services fosters continuity of care and ensures sustained gains in academic and developmental domains for children, youth and their families. A School-Based Mental Health Services (SBMH) workgroup was established to facilitate this collaboration. The goal of the School-Based Mental Health Services (SBMH) collaboration between ADMH and DOE and their local entities is to ensure that children and adolescents, both general and special education, enrolled in local school systems have access to high quality mental health prevention and treatment services.
- From FY 12 and FY 15 to date, sixteen of the 22 community mental health centers (CMHCs) of Alabama and over 60 Local Education Authorities (LEAs) have conducted initial orientation meetings describing the SBMH collaborative process. Of these, 12 CMHCs and 36 School Systems have entered into formalized agreements as SBMH Collaboration Partners. The SBMH model improves access to appropriate mental health services by children who need them by placing a Master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. ADMH and ALSDE continue to jointly promote the School Based Mental Health Collaboration across the state, and have presented workshops on SMBH at ALSDE's MEGA Conference and Transition Conference in FY 12 and every year thereafter through FY15. SBMH Partner CMHCs and School Systems are currently gathering information to establish School Year 2014-2015 as the "baseline year for SBMH Data. This information will be used to analyze the effectiveness of SBMH over subsequent years.
- In 2013, ADMH started participation in an interagency workgroup of the Alabama State Department of Education (ALSDE) to promulgate proposed regulations for "State-Supported Schools." These schools provide educational services for students who are located in facilities that provide treatment and care to children in both Special Education

and General Education. Responsibility for the oversight of these programs and the student's educational progress has historically fallen to the state and not the Local Educational Agencies (LEA). These regulations, if approved by the ALSDE Board, will vest responsibility and oversight in the Local Education Authority (LEA) where the facility is located. This was an important collaboration since ADMH has certification authority for many of the treatment programs identified under "State-Supported". Academic achievement for children with serious emotional disturbances is a significant component in their treatment and a protective factor against all risks as they transition into adulthood.

Social Services/Department of Human Resources (DHR):

The Social Service agency in Alabama is the Department of Human Resources (DHR). Collaboration with DHR occurs at the local and state level to include direct care, blended services, training efforts, coordination, and planning. Social services provided for this population does include in-home and community based care that can be provided by or linked by In-Home Intervention Teams and case management services.

- In 1988, ADMH entered into an agreement with DHR to jointly fund three Family Integration Network Demonstration Projects (FIND). These projects consisted of in-home intervention and case management operated through a CMHC. The FIND programs serve children with serious emotional disturbances and their families who are generally involved with multiple agencies. Currently, there are 51 C&A In-Home Intervention teams across the state. At present, every community mental health center catchment area has a least one designated children's case manager. Children and adolescents may also receive case management from qualified CMHC staff who has been cross-trained in the delivery of case management to both adults and youth.
- Since this first cooperative funding venture with DHR in 1988, the two agencies (ADMH and DHR) have jointly funded the Brewer Porch Short Term Treatment and Evaluation Program (STTEP) and Glenwood's Daniel House. STTEP is designed to provide evaluation and short-term treatment for children who had previously been hospitalized or were at risk of hospitalization. Glenwood Daniel House provides residential treatment for children who would frequently have been placed in an inpatient unit or in a residential program that would not encourage family involvement. In 2007, ADMH and DHR re-crafted this joint collaboration to allow for the contracting of beds in three of Glenwood's premier programs. Daniel House I and Daniel II are residential treatment programs that continue to serve the most severe SED youth and their families, ranging from age six to fourteen. The contract changes also allowed for contract beds in the short-term assessment program, Glenwood Drummond Center II. This 90 day assessment program alleviated the overuse of acute units for inpatient assessment needs and provided thorough recommendations as to assist family members and communities in providing more appropriate treatment. Admissions to these programs are jointly screened by the agencies involved. In FY09, due to budget issues and restructuring of their service system, Glenwood Drummond Center II was closed but the collaboration continued with the other programs.
- ADMH had a contractual collaboration with DHR involving a partnership with a special project of the former First Lady of Alabama; Mrs. Patsy Riley, with the Parenting

Assistance Line (PAL). PAL is a collaborative service of the University of Alabama Child Development Resources and the Alabama Children's Trust Fund. When callers call the toll-free number, a parenting resource specialist will answer the phone, listen to the caller, and then offer helpful information and support. Callers can also request free literature about their specific parenting concerns. Due to the high volume of calls involving PTSD linked to the Hurricanes of 2005, ADMH became a partner with this project providing funds for a state-wide media campaign through billboards, radio, and television to raise awareness of traumatic issues, especially Post Traumatic Stress Disorder. This media campaign started in May 2007. PAL remains operational. However, ADMH no longer participates with funding due to lack of monies.

State Multiple Needs Childs Office:

A Joint Task Force of DHR and ADMH was established in 1991 to address problematic interagency issues. The Task Force established subcommittees to work on conflict resolution procedures, cross-agency training, promotion of coordination at the local level, and planning for future needs. In 1993, the Alabama Legislature passed the amendments to the Juvenile Justice Act, otherwise known as the Multi-need Child Legislation. Patterned after the "clusters" in Ohio, the Act required the establishment of a State Facilitation Team, and facilitation teams in each of Alabama's 67 counties. At a minimum, the agencies mandated to participate include Education, Human Resources (child welfare), Public Health, Mental Health, and Youth Services (juvenile justice). The Multiple Needs Child Act is for children who need services from two or more agencies and are at risk of out-of-home placement or movement into a more restrictive environment. These children's needs are often multifaceted and require intensive collaborative efforts and service coordination from the child care agencies. Currently, the local teams and the state team meet monthly to discuss programmatic and funding issues in an effort to effectively serve the neediest children in the state. The local multineeds teams utilize the provision of social services to assist the consumer and their family with maintaining community level of care in the efforts to avoid out of home placement. The Mental Illness Division continues to support maintenance of effort of $544,000 each year; with ADMH providing $1 million total to cover MI/SA/ID youth through the multiple needs process.

OUR Kids

The OUR Kids Initiative which began is 2002 is a collaboration between the departments of DYS, ADMH, and DHR to serve children and families that have needs that cross each agencies area of responsibility. Our Kids has become an example of Interagency Collaboration to serve children and adolescents in their communities. The OUR kids initiative has been noted by federal reviewing authorities from each department as a good example of interagency collaboration. (Ex. Child and Family Services Review, Mental Health Block Grant, SAMSHA, and the National Center for Mental Health and Juvenile Justice.)

The three state agencies comprising the initiative pool funds together (most of it Children First Dollars) and issue a joint competitive Request for Proposal (RFP) across the state. In order to respond and be eligible for funding, a provider must demonstrate the need for a specific service, the coordination and support of the partners in the county or area, and assure it is not duplicative of other services in the area.

Since 2002, specialized services, not previously available, to targeted populations have been provided through this initiative. The departments have supported community-based programs for children identified as CHINs; Aftercare services for children discharged from DYS with mental health needs; Intensive in-home and psychiatric services for children with mental health and DHR involvement; Intensive In-home services for children with lower cognitive functioning.

Today the OUR Kids Initiative supports 11 different programs across the state with a budget of 860,000 dollars. Since 2002, the initiative has averaged serving over 1300 youth per year, for a total of over 12,000 children and adolescents in their communities. These programs have become a valuable resource for County Multiple Needs Teams and other state and local agencies.

MI Planning Council:

Representatives from many of these organizations are members of, and actively participate on, the Alabama Mental Illness Planning Council (Please see Application Section: Environmental Factors: 22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application and the Application Section: Behavioral Health Advisory Council Members - for Planning Council membership details). The MI Planning Council is tasked with the following responsibilities:

- Advise and assist in the development of the Mental Health Block Grant plans and reports.
- Reviewing and monitoring the Mental Health Block Grant and submitting to ADMH any recommendations for modifications.
- Prepare and submit a separate annual report of progress to the Governor.
- Promote and advocate for improved and innovative services for individuals in Alabama with serious mental illness.
- Participating in improving mental health services within the State.
- Monitoring the portion of the MHBG dollars reserved for Planning Council Special Projects.

To meet the requirements of providing a letter of support indicating agreement with the description of their role and collaboration with the SMHA, attached is letter of support from the MI Planning Council which represents the membership of collaborative partners.

Section IV: Environmental Factors and Plan: 22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

The MI Planning Council has a strong, positive relationship with the ADMH. ADMH does not currently have an integrated MI and SA (behavioral health) Planning Council. ADMH Substance Abuse representatives responsible for the SA Block Grant have actively engaged appropriate SA providers and consumer/family representatives to assist in the development of the SABG.

In previous years, ADMH responded to a BRSS TACS grant to assist with moving toward a single Behavioral Health Planning Council but was not awarded. Also, ADMH representatives and MI Planning Council President has attended SAMHSA Block Grant TA Conferences to determine the

most beneficial avenues to achieve an integrated Behavioral Health Planning Council process and was impacted by the information that most states that have effectively achieved such an effective process has done so over a multiple year process. At present, ADMH has been awarded a BRSS TACS grant but the primary focus in on infrastructure building of SA peer resources. ADMH continues to utilize the MI Planning Council for the SAMHSA Mental Health Block Grant.

The Council strives to ensure that its members is diverse with its membership. The Council relies on the statewide advocacy organizations (WINGS, NAMI, AFT, AYM, AMCC, APSA) and Office of Consumer Relations to nominate the consumer and family representatives on the Council. The Council has 50 members. Thirty two of the members are either consumers or family members. Of the thirty two members, thirteen are consumer representatives, with two of these representatives being in individuals with lived youth experience of SED. In regard to family representatives, there are three parents of children with SED. Within the state employee representatives, there are both adult and youth representatives, as well as the Director of Deaf Services (who is deaf) and the Director of Consumer Relations (an individual with lived experience). The Associate Commissioner and Commissioner are also members of the Council. The other members of the Council are providers of mental health services (public and private) and a single representative from each of the following state agencies: education, child welfare, housing, corrections, youth services, vocational rehabilitation, Medicaid, S-Chip (ALL Kids), as well as two university representatives. There are also legislative representatives, judge representatives, and a member from the Alabama Hospital Association. Currently, the Council membership includes representation of African American members, older adults, consumer and family members of SMI and SED, and members from rural and urban areas.

Appointments to the MI Planning Council are made in several ways (depending on the membership requirements). For consumers, family members, service providers, and legislative representatives, nominations are received and the MI Planning Council's workgroup makes recommendations that are brought back to the full Council for approval. The Council submits a letter of recommendations to the Associate Commissioner who determines if the nominee will be appointed. Each Council member serves a term of two years. Any current member can be re-nominated. Council member terms are reviewed during the November/December meetings. During this time, members with expiring term will be identified and member recommendations are made. Re-appointments and new appointments will be based on participation, mandated representation, and willingness of Council members to serve on the Council. The Council meets at a minimum on a quarterly basis.

The MI Planning Council is very active and participates with other advocacy entities in the expansion of consumer and family voice with the ever changing health climate and Medicaid Reform occurring in Alabama. The planning council participates throughout the year with all phases of Block Grant work to include the review and recommendations for the Block Grant application, the details involved with the goals, priorities, strategies, and performance indicators. They have met several times to review and provide recommendations that led to the creation of the FY16-17 Block Grant application. Each year, they complete mid-year goal review and discuss the data and performance indicators. The MI Planning Council truly guides and steers the planning process. Its members are also vital representatives on the other committees/task forces/councils within ADMH as to maintain a coordinated effort.

The Council develops a letter annually to accompany the MHBG application (see attachment). The letter identifies the activities and accomplishments of the council during the year, as well as challenges and issues that face Alabama's public mental health systems.

Updated Per 07/14/15 Recommendations

ALABAMA MENTAL ILLNESS PLANNING COUNCIL

Family Members – Children and Adolescents				
			Current term	**Proposed**
1.	AL Family Ties	Jacquelyn Scales	12/14	12/17
2.	AL Family Ties	Gloria Hampton	12/14	12/17
3.	AL Family Ties- Alabama Youth Move	Ronitta Ealey	12/12	12/15
4.	AL Family Ties - President	Lisa King	Designated	Designated
Family Members – Adults				
1.	Family Member	Christi Collins	12/31/14	12/17
2.	Family Member	Zina May	12/31/14	12/17
3.	Family Member	Greg Carlson	12/31/14	12/17
4.	Family Member	Melissa Schilling	12/31/14	12/17
5.	Family Member	Mary Ann Hatcher	12/31/14	12/17
6.	Family Member	Mary Elizabeth Perry	12/31/14	12/17
7.	NAMI Ex. Director	Wanda Laird	Designated	Designated
8.	NAMI President	Sue Guffey	Designated	Designated
Consumers				
1.	Wings Ex. Director	Darlene Berry	Designated	Designated
2.	Wings President	Sister Lucindia Claghorn	Designated	Designated
3.	Primary Consumer	Steve Puckett	12/31/14	12/17
4.	Primary Consumer	Mike Herring	12/31/14	12/17
5.	Primary Consumer	Jon Brock	12/31/14	12/17
6.	Primary Consumer	Julius Rickles	12/31/14	12/17

7.	Primary Consumer	Jim Hickman	12/31/14	12/17
8.	Primary Consumer	Jerome Dorsey	12/31/14	12/17
9.	Primary Consumer	Bob Brown	12/31/14	12/17
10.	Dir. Consumer Relations	Mike Autrey	Designated	Designated
11.	AL Minority Consumer Council	Fannie Hicks	Designated	Designated
12.	Adolescent Consumer	Audrey McTyre	12/31/14	12/17
State Employees/University Representatives				
1.	Commissioner	James Perdue	Designated	Designated
2.	Associate Commissioner	Dr. Beverly Bell-Shambley	Designated	Designated
3.	Dept of Educ. Spec. Ed	Martha Holloway	Designated	Designated
4.	Dir. of Comm. Services	Kim Hammack	Designated	Designated
5.	House Fin. Authority	Gary Donegan	Designated	Designated
6.	Human Resources	Starr Stewart	Designated	Designated
7.	Public Health	Cathy Caldwell	Designated	Designated
8.	Rehabilitation Services	James Myrick	Designated	Designated
9.	Youth Services/Correctional Agency	Alesia Allen	Designated	Designated
10.	University Affiliated	VACANT	12/31/12	12/15
11.	Medicaid Agency	Karen Watkins-Smith	Designated	Designated
12.	University Affiliated	Ross Grimes, Ph.D.	12/31/14	12/17
13.	State Coordinator of Deaf Svs.	Steve Hamerdinger	Designated	Designated
14.	Department of Corrections	VACANT	Designated	Designated
Providers				
1.	Council of Community of MH Boards representative	Richard Craig, Ph.D.	12/14	12/17
2.	Council Executive Director	James Dill, Ed.D.	Designated	Designated
3.	Private Provider	Emmett Poundstone	12/31/14	12/17
4.	Private Provider	Steve McCabe	12/31/14	12/17
Others				

1.	AL House	Pebblin Warren	12/31/14	12/17
2.	AL House	Paul Beckman	12/31/14	12/17
3.	AL Senate	Vivian Figures	12/31/14	12/17
4.	AL Senate	Tom Whatley	12/31/14	12/17
5.	Law Enforcement	Judge Tracey McCooey	12/31/14	12/17
6.	MHA Exec. Dir.	Brittany Wiggins	Designated	Designated
7.	MHA President	Will O'Rear	Designated	Designated
8.	Probate Judge	Judge Charles Martin	12/31/14	12/17

FY16-17 Environmental Factors and Plan: Behavioral Health Council Composition by Member Type

The MI Planning Council is extremely active with ADMH in many avenues to include the SAMHSA MH Block Grant. The planning council participates throughout the year with all phases of Mental Health Block Grant work to include the review and recommendations for the Block Grant application, the details involved with the goals, priorities, strategies, and performance indicators. They have met several times to review and provide recommendations that lead to the creation of the Block Grant application. Each year, they complete mid-year goal review and discuss the data and performance indicators. They are active in the participation of each year's MI Implementation Report, as well. The MI Planning Council truly guides and steers the planning process.

Environmental Factors and Plan		
Behavioral Health Council Composition By Member Type		
FY16-17		
Type of Membership	**Number**	**%**
Total Membership	**50**	
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health Services	13	
Family Members of Individuals in Recovery (to inlcude family members of adults with SMI)	10	
Parents of Children with SED	3	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers	6	
Total Individuals in Recovery, Family Members & Others	**32**	**64%**

State Employees	12	
Providers	4	
Federally Recognized Tribe Representative	0	
Vacancies	2	
Total State Employees & Providers	**18**	**36%**
Individuals/Family Members from Diverse Racial, Ethnic, and LBGTQ Populations	6	
Providers from Diverse Racial, Ethnic, and LBGTQ Populations	6	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**12**	
Persons in recovery from or providing treatment for or advocating for substance abuse services		